

No. 2
4-13-40
5-17-39
I X23159

Registration District No. **566**

Primary Registration District No. **3630**

Registrar's No. **146**

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1
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: **Mississippi**
 (a) County **Charleston, Missouri**
 (b) City or town **Charleston, Missouri**
 (c) Name of hospital or institution: **102 N. Heggie Street**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 mo. 25 days.**
 In this community **1** years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Miss.**
 City or town **Charleston**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **102 N. Heggie St.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? **0** years.

3. (a) PRINT FULL NAME **Bobby Lee Stacy**
 (b) If veteran, name war **X X X**
 (c) Social Security No. **X X X**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Nov.** day **15th.**
 year **1940** hour **11** minute **P.** M.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **single**
 6. (b) Name of husband or wife **X X X X**
 6. (c) Age of husband or wife if alive **X X** years
 7. Birth date of deceased **Spet. 21 1940**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov 14**, 19**40**, to **Nov 14**, 19**40**;
 that I last saw him alive on **Nov 14**, 19**40**,
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
0 1 25 hr. min.

Immediate cause of death **Tubercular pneumonia**
 Due to **Enteritis, mucomembranous**
 Duration **2 days**
4 weeks

9. Birthplace **Charleston, Mo. Missouri**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Infant**

Due to **106**
 Other conditions (Include pregnancy within 3 months of death)
 Major findings: Of operations
 Of autopsy

11. Industry or business
 12. Name **Elmer Dennis Stacy**
 13. Birthplace **Columbus Ky.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Alice Counts**
 15. Birthplace **Clarkston Missouri**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Elmer Dennis Stacy**
 (b) Address **Gen. Del. Clarkston, Mo.**
 17. (a) **Burial** (b) Date thereof **11-16-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Charleston, Mo.**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 (Specify type of place) _____
 While at work? (e) Means of injury _____

18. (a) Signature of funeral director **Lair-Nunnelee Service**
Charleston, Mo.
 (b) Address **Charleston, Mo.**
 19. (a) **11-17-40** (b) **J. D. Brown**
 (Date received local registrar) (Registrar's signature)

23. Signature **Paul S. Baum** (M. D. or other) **11/18/40**
 Address **Charleston Mo** Date signed **11/18/40**

RECEIVED

District Health Officer No. 2

District File Number 1240-1754

Date Filed 12/4/48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.