

STANDARD CERTIFICATE OF DEATH

11449

FILED APR 21 1941

State File No.

Registration District No. 507

Primary Registration District No. 4254

Registrar's No.

1. PLACE OF DEATH:  
(a) County Morgan  
(b) City or town Barnett  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community 1 years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Morgan  
(c) City or town Barnett  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Alexander Coleman Stayton  
3. (b) If veteran, name war No  
3. (c) Social Security No. No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 22  
year 1941 hour 12 minute 20 P.M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Dorsey Keller  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April (Month) 11 (Day) 1861 (Year)

21. I hereby certify that I attended the deceased from March 10 1941  
\_\_\_\_\_, 19\_\_\_\_, to March 22, 1941  
that I last saw him alive on March 22, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE: Years 79 Months 11 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cardiac failure in pneumonia  
Due to Myocarditis Chronic  
Due to X

9. Birthplace Mo. (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
Major findings: 95  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name David Stayton  
13. Birthplace Ky. (City, town, or county) (State or foreign country)  
14. Maiden name Frances Hite  
15. Birthplace Ky. (City, town, or county) (State or foreign country)

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

16. (a) Informant Fannie Holden  
(b) Address Barnett, Mo.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-24-41 (Month) (Day) (Year)  
(c) Place: burial or cremation Mo. Pleasant

(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? \_\_\_\_\_

18. (a) Signature of funeral director Phillip S. Home  
(b) Address Barnett  
19. (a) March 24 (Date received local registry) (b) \_\_\_\_\_ (Registrar's signature)

(Specify type of place) \_\_\_\_\_ While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature E. S. Home (M. D. or other) \_\_\_\_\_  
Address Barnett Mo Date signed March 27

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



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 597

Primary Registration District No. 4354

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Morgan
- (b) City or town Barnett  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)
- In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_  
(If rural, give location)
- (e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Alexander Blomau Stanton

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

(Month)

(Day)

(Year)

8. AGE:

Years 79

Months 11

Days 11

If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_

(b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_

(b) \_\_\_\_\_

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 22  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Cardiac failure Duration \_\_\_\_\_  
in Pneumonia

Myocarditis chronic

Due to Unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. Shelton (M.D. or other) \_\_\_\_\_

Address Edson Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11449

Registration District No. 597

Primary Registration District No. 4354

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Morgan
- (b) City or town Barnett  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)
- (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_  
(If rural, give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Alexander Cleman Stanford

- 3. (b) If veteran, name war \_\_\_\_\_
- 3. (c) Social Security No. \_\_\_\_\_

- 4. Sex M
- 5. Color or race W
- 6. (a) Single, widowed, married, divorced M

- 6. (b) Name of husband or wife \_\_\_\_\_
- 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>11</u>	<u>11</u>	hr. _____ min. _____

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

- 12. Name \_\_\_\_\_
- 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)
- 14. Maiden name \_\_\_\_\_
- 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 6/7-41 (b) HG Callison  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 22  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature E. O. Shelton (M. D. or other) \_\_\_\_\_

Address Eldon Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY