b. 2
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X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32705

Registration District No. 421 Primary Registration District No. 6070 Registrar's No.

1. PLACE OF DEATH:

(a) County: Scott

(b) City or town: Rural (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 years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Scott

(c) City or town: Rural (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: Louey Stacy

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: July (Month) 12 (Day) 1884 (Year)

8. AGE: Years 57 Months 2 Days 15 If less than one day hr. min.

9. Birthplace: Scott Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER 12. Name: Frank Stacy

13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Josie Reed

15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Edd Stacy

(b) Address: Vanduser, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-41 (Month) (Day) (Year)

(c) Place: burial or cremation: McMullin, Mo.

18. (a) Signature of funeral director: H. J. Welsh

(b) Address: Sikeston, Mo.

19. (a) 10-15-41 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 year 1941 hour 5 minute A. M.

21. I hereby certify that I attended the deceased from 8-8-41, 19..., to 8-9-41, 19...; that I last saw him alive on 8-8-41, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Bright's disease

Due to: Excessive drinking in his earlier days.

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: [signature] (M. D. or other)

Address: Sikeston Mo Date signed 10/15/41

(Licensed Embalmer's Statement on Reverse Side)

OCT 17 1941

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

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

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

No. 2B
8-21-41
X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32705

Registration District No. 821 Primary Registration District No. 6070 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County: Scott
(b) City or town: Rural
(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 years, months or days)
In this community

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: Lonzy Stacy
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: July 12 1884 (Month) (Day) (Year)
8. AGE: Years 57 Months 2 Days If less than one day 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2 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.

	Duration
Immediate cause of death: Uremia Bright's disease	
Due to: Excessive drinking in earlier days	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 1322	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed