

FILED JUN 16 1942

Registration District No. **241**

Primary Registration District No. **4147**

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

1. PLACE OF DEATH:

(a) County **Dallas**
(b) City or town **BUFFALO MO Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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

3. (a) PRINT FULL NAME **EFFIE MAUD STANLEY**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 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 **8** **3-** **1890**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	9	17	hr. _____ min. _____

9. Birthplace **BUFFALO MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Keeper**

11. Industry or business _____

MOTHER FATHER { 12. Name **R. S. Stanley**
13. Birthplace **277 KNOX** **9**
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Leslie Orr**

(b) Address **BUFFALO MO**

17. (a) **BURIAL** (b) Date thereof **5-22-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Lawn**

18. (a) Signature of funeral director **L. B. Jones**

(b) Address **BUFFALO MO**

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Dallas**
(c) City or town **BUFFALO MO**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **20**
year **1942** hour **3** minutes **30 A.M.**

21. I hereby certify that I attended the deceased from **May 5-19** 19**42**
that I last saw **her** alive on **5-19-42** and that death occurred on the date and hour stated above.

Immediate cause of death **Coma, Diabetes Mellitus, D.K.,**
Major Keller didn't believe
Due to **no factors, therefore**
didn't have any ill
Due to **Coma supervened**
Other conditions **Carbuncle**
(Include pregnancy within 8 months of death) **3 weeks**

Major findings: Of operations **U**
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. G. Plummer** (M. D. or other) **MD**
Address **Buffalo, Mo** Date signed **5/22/42**

RECORDED

JAC BYC

RECEIVED

District Health Officer No. 7,

District File Number 6-42-667

Date Filed 6-15-42

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 Clyde Montgomery
Licensed Embalmer No. 35892
P. O. Address Buffalo 500

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17848

Registration District No. 241

Primary Registration District No. 4147

Registrar's No. _____

PLACE OF DEATH:

(a) County Dallas
(b) City or town Buffalo
(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)

3. (a) PRINT FULL NAME Effie M Stanley

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Aug 3 (Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 21, 43 (b) Helen David (Registrar's signature)

(If in receipt of local registrar)

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 21, year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADE K INK—MAKE A PERMANENT

SUPPLEMENTARY

