

No. 2  
-2-43  
17-39  
X35997

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41875**  
Registrar's No. **382**

FILED JAN 10 1943

Registration District No. \_\_\_\_\_ Primary Registration District No. **3010**

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

1. PLACE OF DEATH:

(a) County **CAPE**

(b) City or town **CAPE GIRARDEAU**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Southeast Missouri Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **30 days** (Specify whether  
In this community **3 days** years, months or days)

3. (a) PRINT FULL NAME **MR. JOHN STANLEY**

3. (b) If veteran,  name war

3. (c) Social Security No.

4. Sex **Male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ira Miller Stanley**

6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **Dec 19, 1874**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>68</b>	<b>11</b>	<b>13</b>	hr. min.

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

10. Usual occupation **Farmer**

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

MOTHER FATHER

12. Name **Don't know**

13. Birthplace **Don't know** **9**  
(City, town, or county) (State or foreign country)

14. Maiden name **Don't know**

15. Birthplace **Don't know** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Harris Stanley**

(b) Address **(Postageville) Mo**

17. (a) **Burial** (b) Date thereof **12-5-1**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Markey Mo**

18. (a) Signature of funeral director **B. Splinghoffer Habbard**

(b) Address **Chaffee Mo**

19. (a) **12-6-43** (b) **F. H. Phelps**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Scott 100**

(c) City or town **Markey Rural**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **2**  
year **1943** hour **3:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **11-30** 19**43** to **12-2** 19**43**  
that I last saw him alive on **12-2-43** and that death occurred on the date and hour stated above.

Immediate cause of death **Urtaemia and chr. Myocarditis**

Due to **Parotite Hypertrophy**

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 **Paul B. Neumann** (M. D. or other) **MD**

Address **Cape Girardeau Mo** Date signed **12-2-43**

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 4  
District File Number 144-315  
Date Filed 1-7-44

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 Mamie Beplinghoff

Licensed Embalmer No. 3242

P. O. Address Chaffee Mo

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan.  
Registrar's No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: D. C. Mo. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 hr. (Specify whether years, months or days) 3 da.

3. (a) PRINT FULL NAME

John C. Stanley

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 54 years

7. Birth date of deceased Dec. 19 1934  
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days \_\_\_\_\_ 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)

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 Dec. day \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_

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 due to chronic heart disease

thrombotic + chronic myocarditis  
Due to Prostate Hypertrophy Duration 5

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 131b  
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 Paul J. [unclear] (M. D. or other) MD  
Address Cape Girardeau Mo. Date signed 1-19-44

5-41875