

FILED JAN 12 1944
Registration District No. 124

Primary Registration District No. 555

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Rural, Mountain View, Mo
(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 NO (Specify whether years, months or days) 3 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell

(c) City or town Mountain View, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Stansbury

3. (b) If veteran, name war NO

3. (c) Social Security No. No

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Lula Stansbury

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased May 17 1868
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>7</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER {

12. Name David Stansbury

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Yandle

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Lula Stansbury

(b) Address R-3 Mountain View, Mo

17. (a) Burial (b) Date thereof Dec. 12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Dell Cem,

18. (a) Signature of funeral director John F. Duncan

(b) Address Mountain View, Mo

19. (a) 12-14 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 11th year 1943 hour 1 minute 50p M.

21. I hereby certify that I attended the deceased from DEC 11 1943 that I last saw him alive on DEC 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to _____

Due to _____

Other conditions 108
(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) (e) Means of injury _____

23. Signature J. J. Bennett (M. D. or other)
Address Melton Springs Date signed Dec 13

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

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.

~~Not Embalmed~~
Signed John F. Deaneau
Licensed Embalmer No. 2516
P. O. Address W. W. Street, 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.*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County *Howell*
(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 _____

3. (a) PRINT FULL NAME *Wm. Stansbury*

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 *May 17*
(Month) (Day) (Year)

8. AGE: Years *75* Months *7* 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 _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

- (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) *Dec. 20, 1943* (Date received local registrar)

Ruth Hunt (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* year *1943* 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 _____

Duration _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-42458