

34020

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 8 1944

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 138

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs, 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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 94  
(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

Martis Stanley

3. (b) If veteran, name war None 3. (c) Social Security No. \_\_\_\_\_

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

8. AGE: Years Months Days If less than one day  
About 83 hr. min.

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

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

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

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant None

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

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17-44 (Month) (Day) (Year)

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

18. (a) Signature of funeral director Clayton Richard

(b) Address Excelsior Springs, Mo.

19. (a) Oct-17-44 (Date received local registrar) Mrs. Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14 year 1944 hour 1:30 minute \_\_\_\_\_ P. 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 Crownay Aneurysm 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) Crownay Aneurysm

(b) Date of occurrence 10-14-1944

(c) Where did injury occur? Ex. Spgs. Clay Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Convalersent Home (Nicol)

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

23. Signature P. W. Prather (M. D. or other)

Address Ex. Spgs. Mo Date signed 10-16-44

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

3-10-2  
2-4-42  
5-17-39  
I X32873

RECEIVED

District Health Officer No. 8,

11-6-44

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

*Carl Rapp*

Licensed Embalmer No. *23458*

P. O. Address *Co. Spgo. 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. *Nov*Registrar's No. *138*Registration District No. *71*Primary Registration District No. *3012*

## 1. PLACE OF DEATH:

- (a) County *Clay*  
 (b) City or town *Excelsior Springs*  
 (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 *Martia Janey*

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

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

7. Birth date of deceased
- unk*
- 
- (Month) (Day) (Year)

8. AGE: Years
- 83*
- Months Days If less than one day
- 
- min.

9. Birthplace
- Switzerland*
- 
- (City, town, or county) (State or foreign country)

10. Usual occupation
- College Professor*

11. Industry or business
- Professor*

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) (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)
- Mrs Sadie Redman*
- (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (d) 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
- Nov*
- day
- 14*
- 
- year
- 1944*
- hour minute M.

21. I hereby certify that I attended the deceased from
- 
- 19.....; 19.....;

that I last saw him/her live on  
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  
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 (b) Date of occurrence  
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 (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 (M. D. or other)

Address Date signed

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

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