V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1944

Registration District No. 379

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35397

Primary Registration District No. 6077

Registrar's No. 50

1. PLACE OF DEATH:
(a) County Ste. Genevieve
(b) City or town River Aux Vases
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonnivars Twp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ste Genevieve
(c) City or town River Aux Vases
(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

3. (a) PRINT FULL NAME WANDA B. STANTON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Warren Stanton
6. (c) Age of husband or wife if alive 44 years
7. Birth date of deceased Jan. (Month) 4 (Day) 1903 (Year)

8. AGE: Years 41 Months 9 Days 2 If less than one day hr. min.

9. Birthplace Ralls Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Nurse
11. Industry or business

MOTHER FATHER
12. Name Ambrose Bersears
13. Birthplace Ralls Co. (City, town, or county) Mo (State or foreign country)
14. Maiden name Myra Viola Butler
15. Birthplace Ralls Co. (City, town, or county) Mo (State or foreign country)

16. (a) Informant Warren Stanton
(b) Address River Aux Vases, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem. Ste. Genevieve, Mo.
18. (a) Signature of funeral director Miller Funeral Home
(b) Address Farmington, Mo.
19. (a) Oct 9/44 (Date received local registrar) (b) T. W. Douglas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6 year 1944 hour 11 minute 45 P. M.
21. I hereby certify that I attended the deceased from Oct 6, 1944, to Oct 6, 1944 that I last saw h. E.R. alive on Oct 6, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration 10/6/44
Due to Hypertension — ?
Due to
Other conditions (Include pregnancy within 3 months of death) 820
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. J. Lanning M.D. (M. D. or other)
Address Ste. Genevieve Mo Date signed 10/7/44

706

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 4

1144-4488

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 Berl J. Miller

Licensed Embalmer No. 3752

P. O. Address Farmington, 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.