S. No. 2
M—8-43
. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1945

Registration District No. 206

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6591

Primary Registration District No. 3042

Registrar's No.

1. PLACE OF DEATH:

(a) County: Madison

(b) City or town: Fredericktown, Mo

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mallow

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether

In this community: Life

years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Madison

(c) City or town: Fredericktown, Mo.

(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: JOE-LEE-STACY

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: S

6. (b) Name of husband or wife: —

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

7. Birth date of deceased: Oct. (Month) 25 (Day) 44 (Year)

8. AGE: Years: 70 Months: 4 Days: 2 If less than one day: hr. min.

9. Birthplace: Madison (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Ray H. Stacy

13. Birthplace: Madison Co. (City, town, or county) Mo (State or foreign country)

MOTHER

14. Maiden name: Ora Parson

15. Birthplace: Madison Co. (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Ray H. Stacy

(b) Address: Fredericktown, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-28-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Methodist Cemetery

18. (a) Signature of funeral director: Webb & Walk

(b) Address: Fredericktown, Mo.

19. (a) Feb 28 1945 (Date received local registrar) (b) S. C. Sleight (Registrar's signature) By B. B. Schwanz

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Feb. day: 27 year: 1945 hour: 8 minute: 30 A. M.

21. I hereby certify that I attended the deceased from Jan 10 - 1945, 19__ to Feb. 26 - 1945, 19__ that I last saw him alive on Feb. 26 - 1945, 19__ and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Failed - Had Pneumonia twice

Due to: Heart failed in heart attack

Due to:

Other conditions: (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): no

(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. B. Barber (M. D. or other)

Address: Fredericktown Mo. Date signed: 3/2/45

481

(Licensed Embalmer's Statement on Reverse Side)

1945

RECEIVED

District Health Officer No. 4

District File Number 345-347

Date Filed 3-7-45

To Embalmer John Holt License #4264

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.