

1. PLACE OF DEATH:
 (a) County Adair
 (b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Laughlin Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 week
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Harrison 4-1
 (c) City or town Cainsville
(If outside city or town limits, write "RURAL")
R. No. 2
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country..... 1

3. (a) PRINT FULL NAME Thomas R. Stanley
 3. (b) If veteran, name war..... 1
 3. (c) Social Security No..... No

MEDICAL CERTIFICATION
 20. **DATE OF DEATH:** Month April day 29
 year 45 hour 1:00 minute P: M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lena Stanley
 6. (c) Age of husband or wife if alive 18 years 1894
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4/23/45
4/29/45 1945 to 4/29/45 1945
 that I last saw h. alive on 4-29-45 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>11</u>	<u>11</u>	hr. min.

Immediate cause of death myocardial infarction
 Duration 3 days

9. Birthplace Harrison Co Ill.
(City, town, or county) (State or foreign country)

Due to Perforation of stomach
 Due to Stomach

10. Usual occupation Farmer

Other conditions 1170
(Include pregnancy within 3 months of death)

11. Industry or business

12. Name Thomas Stanley 4

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

14. Maiden name Cora Craig
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Lena Stanley
 (b) Address Cainsville, Mo.

17. (a) Removal (b) Date thereof 4/29/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Cedar Hill Cemetery

18. (a) Signature of funeral director DEB Riley
 (b) Address Kirksville, Mo.

19. (a) 5-1-45 (b) Mrs. J. W. Wagoner
(Date received local registrar) (Registrar's Signature)

Major findings: Perforation of stomach due to ulcer
 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 Hot No. 10110 (M. D. or other) DC
 Address Kirkville Mo Date signed 4/29/45

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

MAY 16 1945

RECEIVED
District Health Officer No. 10
District File Number 5-45-754
Date Filed MAY 10 1945

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

Derby

Licensed Embalmer No. 4181

P. O. Address

Kingsville 40

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.