

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34095

State File No. _____

FILED NOV 8 1945

Registration District No. 171

Primary Registration District No. 4267

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Odessa
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: _____ (Specify whether)
In this community: 45 Yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Odessa
(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 Thomas W. Staley

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 Single

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased October 24, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 11 18 hr. min.

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

10. Usual occupation Retired

11. Industry or business: _____

12. Name John Staley

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

14. Maiden name Elizabeth Phleger

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

16. (a) Informant Eunice Staley

(b) Address Odessa, Mo.

17. (a) Burial (b) Date thereof Oct. 14, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Odessa, Mo. Cemetery

18. (a) Signature of funeral director Husman-Sparks

(b) Address Odessa, Mo.

19. (a) Oct. 3, 1945 (b) Latta Drummond
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1945 hour 11 minute _____ A.M.

21. I hereby certify that I attended the deceased from Oct 12 to Oct 15, 1945
that I last saw him alive on Oct 5 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Rheumatism

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 920
Of autopsy _____

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)
(c) Means of injury _____
23. Signature [Signature] (M. D. _____)
Address [Address] Date signed 10/13/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

4
7
0

54

4

0

0

1560

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 11-6-45

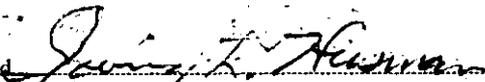
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

W. T. Sparks

Registered Apprentice No. **385**

working under my personal supervision.

Signed 

Licensed Embalmer No. **2541**

P. O. Address **Odessa, 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.