

No. 2  
-12-45  
-17-39

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4127  
State File No. \_\_\_\_\_  
Registrar's No. 78

Registration District No. 43  
Primary Registration District No. 3007

PLACE OF DEATH:  
(a) County BUTLER  
(b) City or town SO. POPLAR BLUFF  
(c) Name of hospital or institution HOME  
(d) Length of stay: 7 YRS.  
In this community 7 YRS.

3. (a) PRINT FULL NAME GEORGE ALLEN STANLEY  
(b) If veteran, name war X  
(c) Social Security No. X

4. Sex MALE  
5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWED  
(b) Name of husband or wife CLARA MAE STANLEY  
(c) Age of husband or wife if alive X years  
7. Birth date of deceased JAN 11 1872

8. AGE: Years 75 Months 1 Days 12

9. Birthplace FRANKFORT KY

10. Usual occupation FARMER (RET)

11. Industry or business FARM

12. Name JAMES STANLEY

13. Birthplace KY

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN

16. (a) Informant W. M. STANLEY

(b) Address RT #2 MILVERN RD. HOT SPRINGS, ARK.

17. (a) BURIAL (b) Date thereof 2-25-47

(c) Place: burial or cremation Band Cemetery, Hot Springs, Ark.

18. (a) Signature of funeral director R. J. Selig

(b) Address Black's Undertaking Co., Hot Springs, Ark.

19. (a) 2/24/47 (b) R. J. Selig

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County BUTLER  
(c) City or town SO. POPLAR BLUFF  
(d) Street No. 209 W. HENRY  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month FEB day 23 year 1947 hour 10 P.m. minute M.  
21. I hereby certify that I attended the deceased from June 1946 to Feb 23 1947  
that I last saw him alive on Feb 23 1947 and that death occurred on the date and hour stated above.  
Immediate cause of death Asphyxiation  
Duration \_\_\_\_\_

Due to Cardiac Failure  
Due to Cardiac-Vascular Disease  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 131A  
Of operations \_\_\_\_\_  
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? \_\_\_\_\_  
(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 R. J. Selig (M. D. or other)  
Address Poplar Bluff, Mo. Date signed 2/25/47

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

MOTHER FATHER

35

RECEIVED  
District Health Office No. 2,  
Phone Number 347-310  
2-4-47

---

---

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 Ramon J. Selig Jr.

Licensed Embalmer No. 562

P. O. Address Corning, N.Y.

**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.**