

FILED MAR 7 3 1947
Registration District No. 360

Primary Registration District No. 6225

1. PLACE OF DEATH:

(a) County Verona
(b) City or town Verona
(c) Name of hospital or institution: State Hospital # 3
(d) Length of stay: In hospital or institution 1 year - 5 mos - 20 days
In this community 1 year - 5 mos - 20 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Lecton
(d) Street No. Rural
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Woodrow 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 Single

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

7. Birth date of deceased 8 21 1917
(Month) (Day) (Year)

8. AGE: Years 29 Months 7 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation carpenter

11. Industry or business _____

12. Name Lewis H Stacy

18. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Myrtle Hull

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

16. (a) Informant Records

(b) Address State Hospital # 3

17. (a) Burial (b) Date thereof 2-26-47
(City, town, or county) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director W. B. ...

(b) Address Lecton Mo

19. (a) 2-24-47 (b) Eastern ...
(Date received in local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 23
year 1947 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 2-21-47 to 2-23-47
that I last saw him alive on 2-23-47
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Perforating ulcer large intestine - illececal junction
Other conditions _____
Major findings: Of operations _____
Of autopsy Findings as above.

Duration

one day

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? _____
(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 0

23. Signature J. R. ... (M. D. certificate) _____
Address State Hospital # 3 Date signed 2-24-47

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

33) Enclosed

RECEIVED
District Health Officer No. 7,
District File Number 2-47-192
Date Filed 3.5-47

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. 710
working under my personal supervision.

Signed W. B. Bunker

Licensed Embalmer No. 62577

P. O. Address Luton, 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, above space should be left blank.