

FILED AUG 4 1947

Registration District No. 385

Primary Registration District No. 3039

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Marceline
(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 10 years years, months or days

3. (a) PRINT FULL NAME

John Everett Stanfield
(b) If veteran, name war _____ (c) Social Security No. 500-09-8665

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Edna Collins Stanfield 6. (c) Age of husband or wife if 51 years

7. Birth date of deceased June 20 1889
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Days 21 If less than one day _____ hr. _____ min.

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

10. Usual occupation R.R. & Farmer

11. Industry or business _____

12. Name Isiah Stanfield

13. Birthplace macon Co mo
(City, town, or county) (State or foreign country)

14. Maiden name Delanie Millsap

15. Birthplace macon Co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J.E. Stanfield

(b) Address Marceline mo

17. (a) Burial (b) Date thereof July 14 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt. Olive

18. (a) Signature of funeral director James Maughlin

(b) Address Marceline mo

19. (a) 7-14-47 (b) Stanfield
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Linn 58
(c) City or town Marceline
(If outside city or town limits, write "RURAL")
(d) Street No. 122 W. Lake
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1947 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
instantly fatal

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 5 months of death)

Major findings: g 3A
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 _____
Where did injury occur? _____ (City or town) (County) (State)
(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature John W. P. [unclear] While at work? _____ (Specify type of place)
Marceline mo Means of injury 2
Address _____ Date signed 7-14-47

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

DISTRICT HEALTH OFFICE
Cameron, Mo.

MAY 28 1958

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

Delburn Keith Tellotson

, Registered Apprentice No. *438*

working under my personal supervision.

Signed *Delburn*

Licensed Embalmer No. *4088*

P. O. Address *Marcelline, 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.