S. No. 2
M—1/47
r. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 11 1947

Registration District No. 3717

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33211

Primary Registration District No. 3066

Registrar's No. 2046

1. PLACE OF DEATH:
(a) County: ST LOUIS
(b) City or town: N. KIRKWOOD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 317 - OAKLEY LANE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: (Specify whether
In this community: 9 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: ST LOUIS
(c) City or town: KIRKWOOD - N
(If outside city or town limits, write "RURAL")
(d) Street No.: 317 - OAKLEY LANE
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: CLARA MAUDE STANGIER
3. (b) If veteran, name war: No
3. (c) Social Security No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: WIDOWED
6. (b) Name of husband or wife: THOMAS J. STANGIER
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: AUGUST (Month) 24 (Day) 1879 (Year)

8. AGE: Years 68 Months 1 Days 6 If less than one day — hr. — min.

9. Birthplace: FORT SCOTT (City, town, or county) KANSAS (State or foreign country)
10. Usual occupation: AT HOME
11. Industry or business:
FATHER
12. Name: GEORGE GALBREATH
13. Birthplace: CHARLESTON (City, town, or county) ILLINOIS (State or foreign country)
MOTHER
14. Maiden name: VIETTA EISENHOWER
15. Birthplace: UNKNOWN (City, town, or county) PENSYLVANIA (State or foreign country)
16. (a) Informant: NELLE S. SEBASTIAN
(b) Address: 317 OAKLEY LANE KIRKWOOD MO
17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof: OCT-2-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: VALHALLA CREMATORY
18. (a) Signature of funeral director: Parkerson Co
(b) Address: WEBSTER GROVES MO.
19. (a) 10-3-47 (Date received local registrar) (b) Paul J. Sharp M.D. (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 30 day Sept. year hour 11 minute 45 P.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.

Duration

Immediate cause of death: Unknown
Due to: good
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury:
Signature: Cecil A. Stamp (M. D. ~~CORONER~~)
Commissioner of Health
Address: Date signed 10-2-47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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

OCT 28 1947

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Groves 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.