

No. 2  
8-43  
-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28750**

FILED SEP 13 1948

Registration District No. **395**

Primary Registration District No. **4551**

Registrar's No. **38**

1. PLACE OF DEATH:  
(a) County **Wright**  
(b) City or town **Hartsville**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**At Her Home in Hartsville**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **None**  
(Specify whether  
In this community **20 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Wright**  
(c) City or town **Hartsville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **At Her Home in Hartsville**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **JAUNITA NELL STACEY**  
3. (b) If veteran, name war  
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Aug.** day **14<sup>th</sup>**  
year **1948** hour **1** minute **15** M.  
21. I hereby certify that I attended the deceased from  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex **F** 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

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death **suicide by drinking carbolic acid** Duration

7. Birth date of deceased **7 19 1928**  
(Month) (Day) (Year)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years **20** Months \_\_\_\_\_ Days **25** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace **Hartsville** (City, town, or county) **MO** (State or foreign country)

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

10. Usual occupation **Housework**  
11. Industry or business  
12. Name **Ray Stacey**  
13. Birthplace **Wright County** (City, town, or county) **MO** (State or foreign country)  
14. Maiden name **Royal Downlow**  
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Mr. E. Lillie Harrison**  
(b) Address **Hartsville Mo.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8 17 48** (Month) (Day) (Year)  
(c) Place: burial or cremation **Moore Cemetery**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **Suicide**  
(b) Date of occurrence **Aug 14, 1948**  
(c) Where did injury occur? **Hartsville, Wright, Mo** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **at Home**

18. (a) Signature of funeral director **Gene E. Halahan**  
(b) Address **Hartsville Mo.**  
19. (a) **Sept. 1, 1948** (Date received local registrar) (b) **E. B. Garner** (Registrar's signature) **01110**

While at work? **no** (Specify type of place) (c) Means of injury **3**  
23. Signature **Gene Stapp** (Registrar) (City or town) Address **Wm. Brown, Mo.** Date signed **8/17/48**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 6;  
District File Number 948-1000  
Date Filed SEP 10 1948

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, ~~only~~.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Gene E. Halchen  
Licensed Embalmer No. 3865  
P. O. Address Hartsville 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5-9-4  
Registrar's No. 38

Registration District No. 375- Primary Registration District No. 4551

1. PLACE OF DEATH:

(a) County Wright  
(b) City or town Hartsville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(if rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Juanita M. Stacey  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color of hair W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased July 17 1944  
(Month) (Day) (Year)

8. AGE: Years 20 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unemployed, house work at home only

11. Industry or business \_\_\_\_\_  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

15. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M. 4  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

28750