OCT 5 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32291

State File No.

BIRTH NO. REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 4644 Registrar's No. 93

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lexington Twp
c. LENGTH OF STAY (In this place) 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Goodloe Nurseing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Ray
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grape Grove Twn. Braymer 1
d. STREET ADDRESS (If rural, give location) Braymer 5 mile E. Hwy. 13 -

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) A.
c. (Last) Stanley

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1953

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH Aug. 24, 1880
9. AGE (In years last birthday) 73 yrs. If under 1 year: Months 10 Days 21 If under 1 hr.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer
10b. KIND OF BUSINESS OR INDUSTRY own farm
11. BIRTHPLACE (State or foreign country) Ray County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Stanley
13b. MOTHER'S MAIDEN NAME Anna Stroughn
14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Virgil Stanley ADDRESS Braymer, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
4201
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25, 1953 *to* Aug 30, 1953, *that I last saw the deceased alive on* Aug 30, 1953, *and that death occurred at* 8:15 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) DO
23b. ADDRESS Braymer, Mo.
23c. DATE SIGNED 9-15-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-17-53
24c. NAME OF CEMETERY OR CREMATORY Cowgill Cem.
24d. LOCATION (City, town, or county) Cowgill (State) Missouri

DATE REC'D BY LOCAL REG. 9-20-53
REGISTRAR'S SIGNATURE [signature] 15/6
25. FUNERAL DIRECTOR'S SIGNATURE MEAD'S Funeral Service B.T.M. ADDRESS Braymer, Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Bernard F. Mead

Licensed Embalmer No. 2801

P. O. Address Braymer, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.