

## STANDARD CERTIFICATE OF DEATH

State File No. 3304

BIRTH NO. FILED FEB 4 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0836

|                                                                                                                                                                                                                                                                                  |  |                                                                                                                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>1</u>                                                                                                                                                                                                                                          |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY      |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>                                                                                                                                                                                    |  | c. CITY OR TOWN <u>St. Louis</u>                                                                                                  |  |
| c. LENGTH OF STAY (in this place)                                                                                                                                                                                                                                                |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2115 Cherokee</u>                                                                                                                                                                                                                     |  | e. STREET ADDRESS (If rural, give location) <u>24 2115 Cherokee 2249</u>                                                          |  |
| 3. NAME OF DECEASED<br>a. (First) <u>James</u>                                                                                                                                                                                                                                   |  | b. (Middle) <u>Benny</u>                                                                                                          |  |
| c. (Last) <u>Stanton</u>                                                                                                                                                                                                                                                         |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1954</u>                                                                        |  |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                               |  | 6. COLOR OR RACE <u>White</u>                                                                                                     |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>                                                                                                                                                                                                      |  | 8. DATE OF BIRTH <u>Jan. 8, 1939</u>                                                                                              |  |
| 9. AGE (In years last birthday) <u>15</u>                                                                                                                                                                                                                                        |  | IF UNDER 1 YEAR Months Days                                                                                                       |  |
| IF UNDER 24 HRS. Hours Min.                                                                                                                                                                                                                                                      |  |                                                                                                                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>                                                                                                                                                                       |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>                                                                                   |  |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>Wardell, Mo.</u>                                                                                                                                                                                                           |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>                                                                                          |  |
| 13a. FATHER'S NAME <u>Robert E. Stanton</u>                                                                                                                                                                                                                                      |  | 13b. MOTHER'S MAIDEN NAME <u>Edith B. DePriest</u>                                                                                |  |
| 14. NAME OF HUSBAND OR WIFE <u>None</u>                                                                                                                                                                                                                                          |  |                                                                                                                                   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>                                                                                                                                                               |  | 16. SOCIAL SECURITY NO. <u>None</u>                                                                                               |  |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Edith Waller</u>                                                                                                                                                                                                                       |  | ADDRESS <u>2115 Cherokee</u>                                                                                                      |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. - It means the disease, injury, or complication which caused death.                                                  |  |                                                                                                                                   |  |
| MEDICAL CERTIFICATION                                                                                                                                                                                                                                                            |  |                                                                                                                                   |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia hypostatic</u>                                                                                                                                                                                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>                                                                                    |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.                                                                                                                                                            |  | DUE TO (b) <u>Anemia, hemorrhagic</u> <u>1 mo</u>                                                                                 |  |
| DUE TO (c) <u>Carcinoma rectum</u> <u>1 yr</u>                                                                                                                                                                                                                                   |  |                                                                                                                                   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                              |  |                                                                                                                                   |  |
| 19a. DATE OF OPERATION <u>Oct 9, 1953</u>                                                                                                                                                                                                                                        |  | 19b. MAJOR FINDINGS OF OPERATION <u>Inoperable Carcinoma rectum</u>                                                               |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                 |  |                                                                                                                                   |  |
| 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) <u>154X</u>                                                                                                                                                                                                                      |  |                                                                                                                                   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                            |  |
| 21f. HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                       |  |                                                                                                                                   |  |
| 22. I hereby certify that I attended the deceased from <u>9-25</u> , 19 <u>53</u> , to <u>1-23</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>54</u> , and that death occurred at <u>6 P. m.</u> , from the causes and on the date stated above. |  |                                                                                                                                   |  |
| 23a. SIGNATURE <u>O. R. Hachmeyr</u> (Degree or title) <u>M.D.</u>                                                                                                                                                                                                               |  | 23b. ADDRESS <u>4703A Virginia Ave</u>                                                                                            |  |
| 23c. DATE SIGNED <u>1-26-54</u>                                                                                                                                                                                                                                                  |  |                                                                                                                                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>                                                                                                                                                                                                                         |  | 24b. DATE <u>1-25-54</u>                                                                                                          |  |
| 24c. NAME OF CEMETERY OR CREMATORY <u>Smith's Cemetery</u>                                                                                                                                                                                                                       |  | 24d. LOCATION (City, town, or county) (State) <u>Caruthersville, Mo.</u>                                                          |  |
| DATE REC'D BY LOCAL REG. <u>JAN 26 1954</u>                                                                                                                                                                                                                                      |  | REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>                                                                                        |  |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>                                                                                                                                                                                                                          |  | ADDRESS <u>4700 Washington Blvd.</u>                                                                                              |  |

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

(Licensed Embalmer's Statement on Reverse Side)

**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.....  
Signature of Student Embalmer

Signed *John J. Haines*  
Licensed Embalmer No. *410*  
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.