

FILED APR 19 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **11765**BIRTH NO. **28035-54** REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **357A**

|                                                               |  |                                                                                                                           |                                                                                                                                   |
|---------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Greene</b>                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence only)<br>a. STATE <b>MO</b> b. COUNTY <b>Wright</b> |                                                                                                                                   |
| b. CITY OR TOWN <b>Springfield, MO</b>                        |  | c. CITY OR TOWN <b>Rayborn</b>                                                                                            | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. LENGTH OF STAY (in this place)                             |  | e. STREET ADDRESS (If rural, give location) <b>1141</b>                                                                   |                                                                                                                                   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Burge Hospital</b> |  |                                                                                                                           |                                                                                                                                   |

|                                                                                                          |                               |                                                                     |                                                                          |
|----------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|
| 3. NAME OF DECEASED<br>(Type or Print) <b>Stanley Dick Lathron</b>                                       |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>April 5, 1954</b>          |                                                                          |
| 5. SEX <b>Male</b>                                                                                       | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Child</b> | 8. DATE OF BIRTH <b>April 3, 1954</b>                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY                                   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Intn Grove, MO</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                                                                 |                               |                                                                     |                                                                          |

|                                          |                                             |                                          |
|------------------------------------------|---------------------------------------------|------------------------------------------|
| 13a. FATHER'S NAME <b>Harvey Lathron</b> | 13b. MOTHER'S MAIDEN NAME <b>Ada Carter</b> | 14. NAME OF HUSBAND OR WIFE <b>Child</b> |
|------------------------------------------|---------------------------------------------|------------------------------------------|

|                                                                                                          |                         |                                                                     |         |
|----------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME <b>Harvey Lathron Rayborn, MO</b> | ADDRESS |
|----------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------|---------|

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION                                                                                                                                         |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2d</b> |
|                                                                                                                                                                                                                                 | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Birth Hemorrhage</b>                                                                       |  |                                               |
|                                                                                                                                                                                                                                 | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                               |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                             |                                                                                                                                                               |  |                                               |

|                        |                                  |                                                                                  |
|------------------------|----------------------------------|----------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|

|                                                       |                                                                                                        |                            |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) | 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 **4-5, 1954**, to **4-5, 1954**, that I last saw the deceased alive on **4-5, 1954**, and that death occurred at **2:30 p.m.**, from the causes and on the date stated above.

|                                                           |                                     |                                 |
|-----------------------------------------------------------|-------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Hubert Busick, MD</b> | 23b. ADDRESS <b>Springfield, MO</b> | 23c. DATE SIGNED <b>4-11-54</b> |
|-----------------------------------------------------------|-------------------------------------|---------------------------------|

|                                                          |                           |                                                          |                                                                  |
|----------------------------------------------------------|---------------------------|----------------------------------------------------------|------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 24b. DATE <b>4-5-1954</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Green Mountain</b> | 24d. LOCATION (City, town, or county) (State) <b>Rayborn, MO</b> |
|----------------------------------------------------------|---------------------------|----------------------------------------------------------|------------------------------------------------------------------|

|                                         |                                               |                                                     |                               |
|-----------------------------------------|-----------------------------------------------|-----------------------------------------------------|-------------------------------|
| DATE REC'D BY LOCAL REG. <b>4-14-54</b> | REGISTRAR'S SIGNATURE <b>Edith Williamson</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Stable Wood</b> | ADDRESS <b>Intn Grove, MO</b> |
|-----------------------------------------|-----------------------------------------------|-----------------------------------------------------|-------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

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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 *Frank Grable*.....

Licensed Embalmer No. *4146*

P. O. Address *Santa Rosa*.....

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.