

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN MARINE	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 68 DAYS		e. STREET ADDRESS (If rural, give location) 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.			

3. NAME OF DECEASED (Type or Print) a. (First) BRUCE b. (Middle) R. c. (Last) STANNARD			4. DATE OF DEATH (Month) (Day) (Year) 5-30-54		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, MARRIED	8. DATE OF BIRTH 8-20-79	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL			11. BIRTHPLACE (City and State or Foreign Country) EAGLE, TEXAS		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME CORNELIUS STANNARD	13b. MOTHER'S MAIDEN NAME MARCELLA (UNKNOWN)	14. NAME OF HUSBAND OR WIFE LOUISE A. STANNARD
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or date of service) SPAW & WWI	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME VA HOSP. RECORDS, ST. LOUIS, MO. ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIOSCLEROTIC HEART DISEASE		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ESOPHAGEAL HIATUS HERNIA		UNKNOWN	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from **3-23**, 19 **54**, to **5-30**, 19 **54**, and that death occurred at **10:40 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE James J. Seeley MD (Degree or title)	23b. ADDRESS VAH, ST. LOUIS, MO.	23c. DATE SIGNED 5-30-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-30-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Alhambra, Ill.
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DATE REC'D BY LOCAL REG. JUN 1 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.
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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, ~~by~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elton H. Penelins*.....

Licensed Embalmer No. *4283*.....

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.