

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22380

State File No.

BIRTH NO.		REG. DIST. NO. <u>55</u>		PRIMARY REG. DIST. NO. <u>3011</u>		Registrar's No. <u>198</u>			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Carrollton</u>		c. LENGTH OF STAY (In this place) <u>Life</u>		c. CITY OR TOWN <u>"Rural"</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Atwood Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>1 mi. N. of Carrollton</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>MILTON</u> b. (Middle) <u>-</u> c. (Last) <u>STANDLEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 17 1954</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec 29, 1882</u>			
9. AGE (In years if under 1 year; last birthday) <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Carroll Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Robert Standley</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Goodson</u>			14. NAME OF HUSBAND OR WIFE <u>Aileen Rea Standley</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 ADDRESS <u>Mrs. Milton Standley, Carrollton Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cholelithiasis</u>				ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				DUE TO (b) <u>History of Gall-stone attacks for 20 yrs.</u>					
				DUE TO (c) <u>Cholelithiasis</u>					
II. OTHER SIGNIFICANT CONDITIONS				Following removal of Gall bladder second operation for paralytic ileus + drain inserted					
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 <u>7-14</u> , 19 <u>54</u> , to <u>7-17</u> , 19 <u>54</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:05 P.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>William S. Atwood</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Carrollton Mo</u>		23c. DATE SIGNED <u>7-19-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>7-20-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Carrollton Mo.</u>			
DATE REC'D BY LOCAL REG. <u>7/20/54</u>		REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvat</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Atwood & Libson</u>		ADDRESS <u>Carrollton Mo.</u>			

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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..... Ben W. Gibson

Licensed Embalmer No. 296

P. O. Address..... Carroll

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.