

XC-18098027

RN-7893

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40264

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Poplar Bluff</b>		c. CITY OR TOWN <b>Bernie</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>7 days</b>		e. STREET ADDRESS (If rural, give location) <b>1030</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>VA Hosp. FAR</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>AARON</b> b. (Middle) <b>MITCHELL</b> c. (Last) <b>STANFIELD</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>December 11, 1954</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>August 26, 1916</b>	9. AGE (In years last birthday) <b>38</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Malden, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>HENRY STANFIELD</b>		13b. MOTHER'S MAIDEN NAME <b>INEZ PYLE</b>		14. NAME OF HUSBAND OR WIFE <b>DELLA STANFIELD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>703035774</b>		17. INFORMANT'S SIGNATURE OR NAME <b>VA HOSPITAL RECORDS</b>	
(If yes, give war or dates of service) <b>WW II</b>				ADDRESS	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute renal failure, lower nephron syndrome.</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Burns, skin, 2nd &amp; 3rd degree, 80% of body area.</b> DUE TO (c) <b>Pneumonia, bronchial type</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocardial insufficiency, toxic basis</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) <b>Accident</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>auto parts store</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Bernie, Stoddard, Mo.</b>

21d. TIME OF INJURY <b>Dec. 11, 1954</b>	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Gas fire</b>
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22. I hereby certify that I attended the deceased from **Dec. 4, 1954**, to **Dec. 11, 1954**, and that death occurred at **8:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Begin on this line) <b>RAUL L. RAMOS, M.D. Acting Chief Surg. Ser.</b>	23b. ADDRESS <b>VA Hospital Poplar Bluff, Mo.</b>	23c. DATE SIGNED <b>12-13-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12-14-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bernie</b>
24d. LOCATION (City, town, or county) (State) <b>Bernie, Missouri</b>		

DATE REC'D BY LOCAL REGISTERAR'S SIGNATURE <b>12/18/54</b>	REGISTRAR'S SIGNATURE <b>W. A. Strickland-Rainey</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Strickland-Rainey</b>	ADDRESS <b>Dexter, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
DEC 21 1954

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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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 Lucille Rainey....., Student Embalmer No. 50..... working under my personal supervision..

Student Lucille Rainey  
Signature of Student Embalmer

Signed J. Stouffer  
Licensed Embalmer No. 347

P. O. Address West.....

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.