

Health,
Welfare
Public
Service

FILED SEP 9 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28056

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 870

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS (If outside, give location) 1446 N. Forrest	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb 60 Yrs.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CLYDE Middle M. Last STANLEY			4. DATE OF DEATH Month Sept. Day 5 Year 1957		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug. 1883	9. AGE (In years last birthday) 74	10. FUNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Iowa	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Stanley	13b. MOTHER'S MAIDEN NAME Alice Mitten	14. NAME OF HUSBAND OR WIFE Edna Stanley
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war and dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Hospital Records
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal Disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 442x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Aug 1, 1957 to Sept. 4, 1957 and last saw ^{him} alive on Sept. 4, 1957 Death occurred at 12:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lyman M. Brown M.D.	22b. ADDRESS Springfield, Missouri	22c. DATE SIGNED 9/5/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-7-57	23c. NAME OF CEMETERY OR CREMATORY Robberson Prairie	23d. LOCATION (City, town, or county) GREENE Co - Mo. (State)
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24. FUNERAL DIRECTOR J. Klingner & Co.	ADDRESS Spgrd. Mo.	25. DATE RECD. BY LOCAL REG. 9-5-57	26. REGISTRAR'S SIGNATURE Edna Williamson
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Greene	Missouri	Greene	Missouri
X	Corningfield	X	Corningfield
X	JAMES M. FOREST	60 Yrs.	City Hospital
Sept. 2, 1933	STATION	X	CLIPPE
74	II Ave. 1883	X	White
USA	Iowa	Retired	Warren
From Stanley	Alice Mitten	Charles Stanley	Charles Stanley
Hospital Records	Unknown	No	No

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

Licensed Embalmer No. 407
P. O. Address

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.