

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1959 93

59-024609

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 59-56 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u> c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u> c. CITY OR TOWN <u>Lockwood Mo</u> d. STREET ADDRESS (If outside, give location) <u>Lockwood Mo</u>	
Length of stay in 1b <u>3 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ina</u> Middle <u>Bib</u> Last <u>Stanley</u>			4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> <u>Widowed</u> <input checked="" type="checkbox"/> <u>Divorced</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21 1875 83</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Vernon Co Mo</u>	11. BIRTHPLACE (City and state or country) <u>usa</u>
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13a. FATHER'S NAME <u>William Turner</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah McLeroy</u>	14. NAME OF HUSBAND OR WIFE <u>Lon Stanley</u>
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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 Address <u>Bertha Daughtrey Lockwood Mo.</u>
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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) <u>cerebral vascular accident</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive Heart failure</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 2-23-59 to 7-13-59 and last saw her alive on 7-13-59.
 Death occurred at 9:55p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Emer W. Taylor M.D.</u>	22b. ADDRESS <u>807 main st. Lockwood, Mo</u>	22c. DATE SIGNED <u>7/16/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 16 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Daughtrey</u>	23d. LOCATION (City, town, or county) (State) <u>Dade Co Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7/20/1959</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greensfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.