

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-041887**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 256 Primary Registration District No. 5879 Registrar's No. 3

STATE FILE NUMBER

**FILED NOV 27 1961**

1. PLACE OF DEATH a. COUNTY <b>OSAGE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>OSAGE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Benton Twp</b>		Length of stay in 1b <b>life</b>	c. CITY OR TOWN <b>Chamois</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>at his home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RFD</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Austin</b> Middle <b>M</b> Last <b>Staley</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1961</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1889</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Mint Hill Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Staley</b>		13b. MOTHER'S MAIDEN NAME <b>Louise Matthews</b>		14. NAME OF HUSBAND OR WIFE <b>Anna Malan Staley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs Clarence Brandt Chamois, Mo</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Massive Coronary Thrombosis</b>	<b>40 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Thrombo-embolitis (2 months previous) of left lower leg</b>	<b>3 months</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) <b>Viral pneumonia right 2 lobes (lower) (2 months previous)</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
---	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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

21. I attended the deceased from 7-15-61 to 11-20-61 and last saw <sup>her</sup>him alive on 10-13-61.  
Death occurred at 6:55 AM. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>F. B. Farnsworth, D.O.</b>		22b. ADDRESS <b>Chamois Mo</b>	22c. DATE SIGNED <b>11-21-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/22/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shirley Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Chamois Mo</b>

24. FUNERAL DIRECTOR <b>Clyde Morton</b>	ADDRESS <b>Linn Mo</b>	25. DATE RECD. BY LOCAL REG. <b>11/22/61</b>	REGISTRAR'S SIGNATURE <b>Josephine Schieder</b>
---	---------------------------	---	--

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Vernon M. Norton

Licensed Embalmer No. 4125

P. O. Address Lean, Mo.

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.