

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

12548

**1. PLACE OF DEATH**

County Jackson  
Township Spain  
City St. Jo

Registration District No. 3004  
Primary Registration District No. Grand Ave

File No. \_\_\_\_\_  
Registered No. 11771  
St. \_\_\_\_\_ (Ward)

**2. FULL NAME**

Mrs. Ming E. Stofur  
(a) Residence No. 3004 Grand Ave St. 3 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. H. Stofur

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 12<sup>th</sup> 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
62 9 21

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work at Home  
(b) General nature of industry, business, or establishment in which employed (or employer) ✓  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Illinois

10. NAME OF FATHER M. E. Elder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no data

12. MAIDEN NAME OF MOTHER Elizabeth Huff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no data

14. INFORMANT Alma Stofur  
(Address) 3004 Grand

15. FILED 4/3, 1930 M. M. Crowe REGISTRAR  
ass

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/3/30 1930

17. I HEREBY CERTIFY, That I attended deceased from June 2 - 1930, to Apr 3 - 1930.  
That I last saw her alive on Apr 3 - 1930, and that death occurred, on the date stated above, at 2:35 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Hypertrophic Proxymyoma

CONTRIBUTORY Acute Cardiac Dilatation (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. Garden City, Kans.

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? E. spec.  
(Signed) E. J. Schneider, M. D. O.

Apr. 3, 1930 (Address) 715 Bryant Bldg.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Ship

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Garden City, Kas 4/4 1930

20. UNDERTAKER ADDRESS  
H. F. Mayberry City, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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2  
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