

Registration District No. 35

Primary Registration District No. 1001

Registrar's No. D-597

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4814 King Hill Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Years (Specify whether years, months or days)

In this community 15 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Stafford

(b) If veteran, name war no

3. (c) Social Security No. 493-14-6695

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lizzie Stafford

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased July 11, 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	10	28	hr. min.

9. Birthplace Filmore Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Interior Decorator

11. Industry or business _____

MOTHER FATHER

12. Name Samuel Stafford

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Delia Sparks

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lizzie Stafford

(b) Address 4814 King Hill Ave.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof June 12, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Filmore, Mo.

18. (a) Signature of funeral director Black Mortuary

(b) Address 5025 King Hill Ave.

19. (a) June 12-1941 (Date received local registrar)

(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 4814 King Hill Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1941 hour 11:45 P. M. (Specify time)

21. I hereby certify that viewed the deceased June 9, 1941 to June 9, 1941 that I last saw h alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to General arteriosclerosis

Due to _____

Other conditions 94
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy no

Duration 1 day

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 5

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature H F Mandy (M. D. or other) P.A.

Address 404 So 3rd St Date signed 6/10/41

OCT 29 1956

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Obry J. Ester

.....
Licensed Embalmer No. *4154*

P. O. Address.....

St. Joseph, m

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 this body is not embalmed, fact should be so stated above.