

No. 2
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-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 22

FILED JAN 4 1944

Registration District No. _____

Primary Registration District No. 5463A

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

1. PLACE OF DEATH:

(a) County Greene Co Mo

(b) City or town Springfield

(c) Name of hospital or institution: Home

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town RR # 2 Shoppers, Mo (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Junior Sanford

3. (b) If veteran, name war ✓

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20 day see year 1943, hour 5 minute 30 M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased see 30 1943

(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12/30 1943 to 12/20 1943 that I last saw him alive on 12/27 1943 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

hr. min.

Immediate cause of death Pneumonia

Due to Dry

9. Birthplace Dallas Co Mo

(City, town, or county) (State or foreign country)

Due to 330

10. Usual occupation _____

Other conditions Indigestion

(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business _____

12. Name James Day Sanford

13. Birthplace Dallas Co Mo

(City, town, or county) (State or foreign country)

14. Maiden name Mertie Howard

15. Birthplace Dallas Mo

(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy no

16. (a) Informant James Day Sanford

(b) Address Springfield Mo RR # 2

17. (a) Sanford (b) Date thereof 12/30-43

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sanford Cemetery

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? _____

18. (a) Signature of funeral director H. J. ...

(b) Address Springfield Mo

19. (a) Dec. 30/43 (b) Richard Harrison

(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature R. F. ... (M. D. or other)

Address Springfield Date signed _____

1246

(Licensed Embalmer's Statement on Reverse Side)

MO

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.....

Licensed Embalmer No.....

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. 22

Registration District No. 130 Primary Registration District No. 5463 A

1. PLACE OF DEATH:

(a) County... Shrew
(b) City or town... Jackson Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Stratford mo RFD#2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... (Specify whether
In this community... years, months or days)

3. (a) PRINT FULL NAME Junior Sanford
3. (b) If veteran... name war...
3. (c) Social Security No.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced... S
6. (b) Name of husband or wife...
6. (c) Age of husband or wife if alive... year

7. Birth date of deceased... Dec 30 1943
(Month) (Day) (Year)

8. AGE: Years 2 Months Days If less than one day... min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof... (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12/30/43 (b) Harland Harrison
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State... (b) County...
(c) City or town... (If outside city or town limits, write "RURAL")
(d) Street No... (If rural, give location)
(e) Citizen of foreign country?... (Yes or No)
If yes, name country...

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 30 Year 1943 Hour 10 minute 0 M.

21. I hereby certify that I attended the deceased from... 19...
that I last saw him... alive on... 19...
and that death occurred on the date and hour stated above.
Immediate cause of death

Due to

Due to

Other conditions... (Includes pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature... (M. D. or other)

Address... Date signed

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-42327