S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 23 1945

State File No. .....

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 917

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural, N. Campbell Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route 6 / (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Rural - Springfield, N. Campbell Twp. (If outside city or town limits, write "RURAL")

(d) Street No. Route 6 (If rural, give location) 0

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

If yes, name country 0

3. (a) PRINT FULL NAME Leroy Thomas Gifford

3. (b) If veteran, name war World War I

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife UNK.

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

7. Birth date of deceased August (Month) 17, (Day) 1894 (Year)

8. AGE:	Years	Months	Days	If less than one day
✓	51	2	21	..... hr. ..... min.

9. Birthplace UNK. (City, town, or county) Iowa / (State or foreign country)

10. Usual occupation Retired.

11. Industry or business

FATHER
12. Name C. Benton Gifford
13. Birthplace Unknown (City, town, or county) Iowa / (State or foreign country)

MOTHER
14. Maiden name UNK.
15. Birthplace UNK. (City, town, or county) UNK. 4 (State or foreign country)

16. (a) Informant Mrs. Bessie Gifford
(b) Address [illegible] Springfield, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri

19. (a) 11-9-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

984

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8th, year 1945 hour 7:20 minute A. M.

21. I hereby certify that I attended the deceased from Nov 6, 1945, 19..., to Nov 8, 1945 that I last saw him alive on November 7, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 Days
Due to: arterial hypertension	?
Due to:	
Other conditions (Include pregnancy within 3 months of death)	83a!

Major findings:
Of operations .....
Of autopsy .....

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury 2

23. Signature William J. Campion (M. D. or other) LSO
Address Landers Bldg - Springfield Date signed 11-8-45

(Licensed Embalmer's Statement on Reverse Side)

NOV 26 1945

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.

X