S. No. 2
M—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30035

FILED SEP 20 1946

Registration District No. 2000

Primary Registration District No. 2000

Registrar's No. 195a

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

39
2
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1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: Springfield Baptist Hosp.
(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 Christian 22

(c) City or town Rural -
(If outside city or town limits, write "RURAL")

(d) Street No. Route #1 (Rogersville) 0
(If rural, give location) 0

(e) Citizen of foreign country? ..... (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME Maude Bell Stafford

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Oct. (Month) 17 (Day) 1900 (Year)

8. AGE: Years 45 | Months 4 | Days 7 | If less than one day ..... hr. ..... min.

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

10. Usual occupation Housewife

11. Industry or business .....

FATHER
12. Name W. M. Manes
13. Birthplace UNK. (City, town, or county) Ark. 1 (State or foreign country)

MOTHER
14. Maiden name Lula Bagley
15. Birthplace UNK. (City, town, or county) Ark. 1 (State or foreign country)

16. (a) Informant Mr. J. J. Stafford
(b) Address Route #1 - Rogersville - Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-46 (Month) (Day) (Year)

(c) Place: burial or cremation Sparta Cem.

18. (a) Signature of funeral director Kelley - Ferrell Funeral Home
(b) Address Rogersville, Mo.

19. (a) 9-10-46 (Date received local registrar) (b) Dr W. E. Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24 year 1946 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from 1 Jan 30, 1946 to Feb 24, 1946 that I last saw her alive on Feb 24, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Localized peritonitis

Due to perforated duodenal ulcer

Due to

Other conditions Gall Stones 126
(Include pregnancy within 3 months of death)

Major findings: Of operations Perforated duodenal ulcer posterior

Of autopsy .....

Duration

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 0

23. Signature Robert Glynn (M. D. or other) MD

Address Springfield, Mo. Date signed 4/4/46

174
9-46

111

(Licensed Embalmer's Statement on Reverse Side)

SEP 20 194

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.