

Health,
& Welfare
Public
Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19325
STATE FILE NUMBER
4678

FILED MAY 27 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar No. 4678

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Essex	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital				Length of stay in lb 2 Hrs.		d. STREET ADDRESS (If outside, give location) Rural Rt. # 2	
3. NAME OF DECEASED (Type or print) First Willard Middle Stafford Last Stafford				4. DATE OF DEATH Month May Day 16 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, 1900	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months 57 Days 57		IF UNDER 24 HRS. Hours 57 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Sidney, Arkansas.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Alfred Stafford			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Vada Stafford, Essex, Mo. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniothorax; Branchial Asthma; Peptic Ulcer. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Branchial Asthma; DUE TO (c) Peptic Ulcer.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2417				
20c. TIME OF INJURY Hour 9:30 A Month 5 Day 17 Year 1957 a. m. 57 p. m. 57							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 9:30 A m on the date stated above; and to the best of my knowledge, from the causes stated							
22a. SIGNATURE James M Kelly (Degree) Deputy Coroner				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 5-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-17-57		23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Dexter, Missouri	
24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington,				25. DATE RECD. BY LOCAL REG. MAY 17 '57		26. REGISTRAR'S SIGNATURE Carl Smith MD MFB	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Student Embalmer No. working under my personal supervision. . .

Student
Signature of Student Embalmer

Signed *Robert M Murray*
3749

Licensed Embalmer No.

P. O. Address *St Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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