

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026284  
STATE FILE NUMBER

FILED JUL 21 1958

Registration District No. 209 Primary Registration District No. 576-1 Registrar's No. 2811

S. 300  
v. 1-57  
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1. PLACE OF DEATH a. COUNTY <b>Marion</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Marion</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Palmyra</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Hannibal</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Maple Lawn Rest Home</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>731 Bridge Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle Last <b>STAFFORD</b>			4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 29, 1887</b>		9. AGE (In years last birthday) <b>70</b> IF UNDER 1 YEAR Months <b>9</b> Days <b>2</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Moline Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13a. FATHER'S NAME <b>Joe Stafford</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann Davis</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. VanHouten Hannibal Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____					
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.) <b>5810</b>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 <b>June 1 - 1958</b> , to <b>July 1 - 1958</b> and last saw her alive on <b>July 1 - 1958</b> Death occurred at <b>9:30 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>J. J. Ramsey M.D.</b> (Degree or title)		22b. ADDRESS <b>Palmyra Mo</b>		22c. DATE SIGNED <b>7/7/58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/3/1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	
				23d. LOCATION (City, town, or county) (State) <b>Palmyra Missouri</b>	
24. FUNERAL DIRECTOR <b>W. Crawford Smith Hannibal Missouri</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-7-58</b>	
				26. REGISTRAR'S SIGNATURE <b>W. E. M. Lunde</b> <b>Pat. T. Lunde Secy. Deputy</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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**RECEIVED** JUL 17 1950

**MARION CO. HEALTH DEPT.**

**DATE FILED** JUL 17 1950

**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 *H. Crawford Smith* .....

Licensed Embalmer No. .... 3814 .....

P. O. Address .. Hannibal Missouri

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.