

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000365
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mercer	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Mill Grove
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		Length of stay in 1b 3 yrs.	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) JAMES VANDERFORD			4. DATE OF DEATH January, 11, 1959		
First	Middle	Last	Month	Day	Year

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mill Grove, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Milt Vanderford	13b. MOTHER'S MAIDEN NAME Mary Ellen Waddle	14. NAME OF HUSBAND OR WIFE Carrie Venderford, deceased
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT Clifford Minshall, Spickard, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost.	DUE TO (b) Arteriosclerotic Disease	unknown
	DUE TO (c) 4500	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Man has been a patient in State Hospital #2, since, Feb. 11, 1956		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) Diagnosis, Chronic Brain Syndrome
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. Associated with Senile Brain Disease
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20d. INJURY OCCURRED WHILE AT <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
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21. I attended the deceased from Jan. 11, 1959 to Jan. 11, 1959 and last saw ^{her} him alive on Jan. 11, 1959 Death occurred at 11:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. F. Mundy M.D. (Degree or title)	22b. ADDRESS St. Joseph, Mo.	22c. DATE SIGNED Jan 12 - 1959
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 14, 1959	23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	23d. LOCATION (City, town, county) (State) Mercer County, Missouri
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24. FUNERAL DIRECTOR Schooler Funeral Home (GAS)	ADDRESS Spickard, Mo.	25. DATE RECD. BY LOCAL REG. Jan 12, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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Dr. H. F. Mundy
All diseases in Part I must be causally related.

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer/Statement on Reverse Side)

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 *Charles E. Bennett*

Licensed Embalmer No. *21677*
P. O. Address *St. Joseph*

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.