

Dr. Stufflebam  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

-63-005996

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER:

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 325

DO NOT WRITE ON THIS STUD

AMENDED

FILED MAR 6 1963

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>GREENE</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MISSOURI</b> b. COUNTY<br><b>CEDAR</b>                  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>SPRINGFIELD</b>   |   | Length of stay in: 1b.<br><b>1 DAY</b>  | c. CITY OR TOWN<br><b>STOCKTON</b><br>Inside Limits:<br>Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>BAPTIST HOSP.</b>   |   | Inside Limits:<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>1204 SOUTH ST.</b><br>Reside on: Farm:<br>Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>      |
| 3. NAME OF DECEASED (Type or print)<br>First: <b>RAY</b> Middle: <b>SAMUEL</b> Last: <b>DEGRAFFENREID</b>  |   | 4. DATE OF DEATH<br>Month: <b>FEB.</b> Day: <b>28</b> Year: <b>1963</b>   |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married: <input checked="" type="checkbox"/> Never Married: <input type="checkbox"/><br>Widowed: <input type="checkbox"/> Divorced: <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1/12/88</b>   |
| 9. AGE (last birthday)<br><b>75</b>  |   | IF UNDER 1 YEAR: Months: Days: Hours: Min.  | IF UNDER 24 HR:  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FARMING</b>   | 11. BIRTHPLACE (City and state or country)<br><b>MORRISVILLE, MO.</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13a. FATHER'S NAME<br><b>JOSEPH DEGRAFFENREID</b>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>MARTHA GRIFFIN</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>ZORA DEGRAFFENREID</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>CLUDE DEGRAFFENREID, STOCKTON, MO.</b>   |   | Address:  |  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Central vascular accident</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:<br>DUE TO (b) <b>generalized arteriosclerosis</b><br>DUE TO (c) |   |   | 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)<br><b>Diffuse toxic goiter</b>   |   |   | PART III. If deceased was female: was there: a) pregnancy; in last 90 days:<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input 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.)  |  |
| 20c. TIME OF INJURY<br>Hour: a.m. p.m.<br>Month, Day, Year:  | 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: <b>2-27-63</b> to: <b>2-28-63</b> and last saw her: <b>2-28-63</b><br>Death occurred at: <b>8<sup>00</sup> p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Robt. E. Stufflebam M.D.</b>  |   | 22b. ADDRESS<br><b>1211 S. Hanstone</b>   | 22c. DATE SIGNED<br><b>3-1-63</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>3/3/63</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>STOCKTON CITY CEM.</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>STOCKTON, MO.</b>  |
| 24. FUNERAL DIRECTOR<br><b>H.H. LOHMEYER FUNERAL HOME</b><br><b>SPRINGFIELD, MO.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>3-5-63</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Effie S. Meltzer</b>   |

Form 2-28-63

**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 Lucius T. Swadley

Licensed Embalmer No. 4875

P. O. Address Springfield, Mo.

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.