

EC 16 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Dallas
Township N. Benton
City Buffalo (No. _____)

Registration District No. 241
Primary Registration District No. 3-334

File No. 41099
Registered No. 1167
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

Kenneth Stafford Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>10-6-1937</u>		
7. AGE YEARS	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Co. Mo.</u>		
13. NAME <u>Kenneth Stafford</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Co. Mo.</u>		
15. MAIDEN NAME <u>Rose Hiltebrand</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dallas Co. Mo.</u>		
17. INFORMANT (ADDRESS) <u>Kenneth Stafford Buffalo Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rever Vejo</u> DATE <u>10-7-37</u>		
19. UNDERTAKER (ADDRESS) <u>L.B. Jones Buffalo Mo.</u>		
20. FILED <u>11/0</u> <u>197</u> <u>Narany Morrow</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-6-37

22. I HEREBY CERTIFY, That I attended deceased from 10-6, 1937, to _____, 1937.
I last saw h. _____ alive on _____, 1937. Death is said to have occurred on the date stated above, at 10 a.m.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage incident to toxemia delivery

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1937.
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) O. O. Garrison, M. D.
(Address) Buffalo Mo.

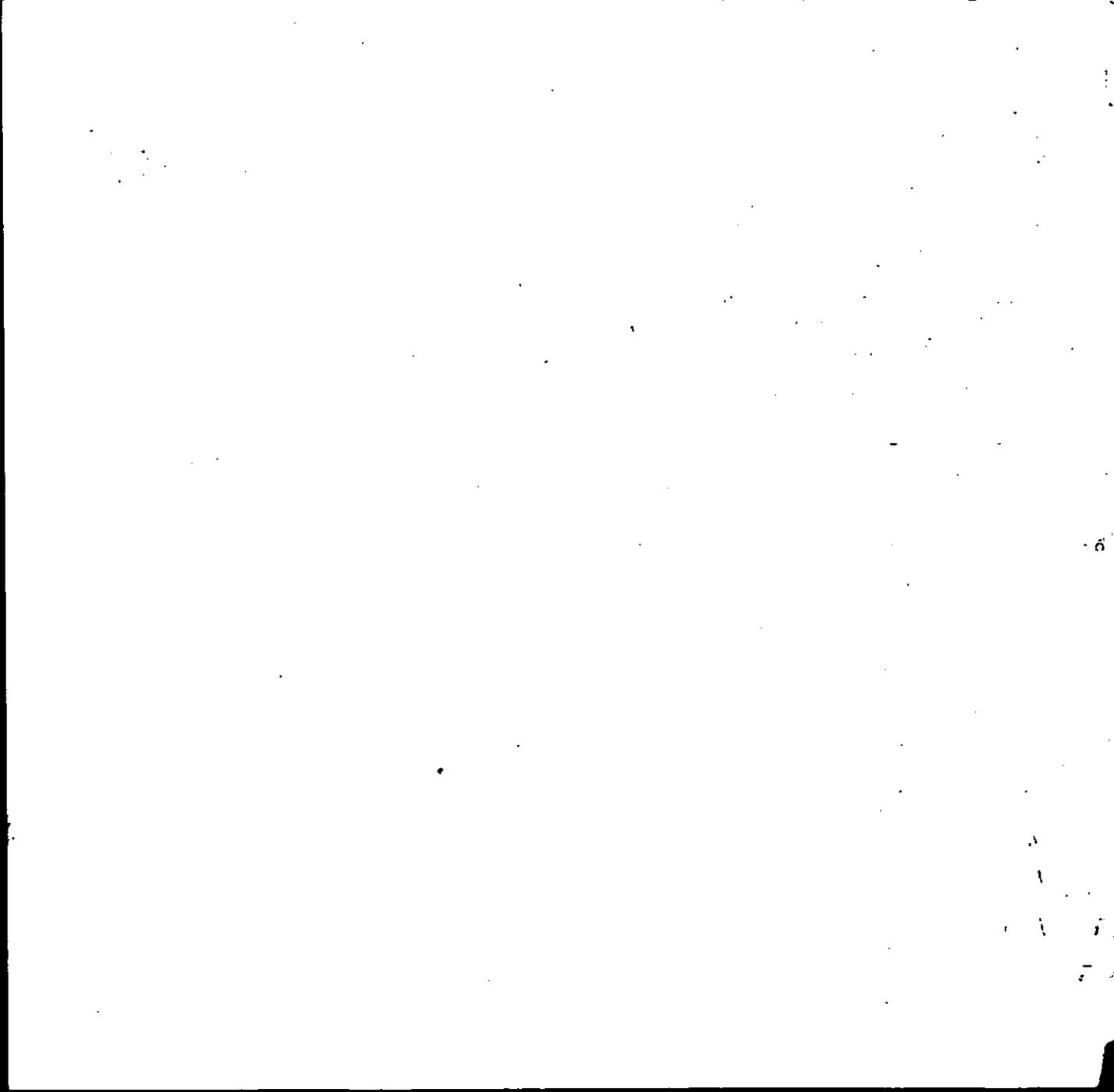
OCCUPATION

FATHER

MOTHER

Date of onset

160



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

41099

Do not use this space.

Registered No. 1169

1. PLACE OF DEATH
- (a) County Dallas Registration District No. 241
- (b) Township 7. Benton Primary Registration District No. 5334
- (c) City..... (d) Street No..... St. (If death occurred in Hospital or Institution, write its name instead of street and number)
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Kenneth Stafford Jr.
- (a) Residence, No. St. (If nonresident, give city or town and State)
- (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-6-1937

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from, 19... to, 19....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-6-1937

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Date of onset

Acute diarrhea

13. NAME

Name of operation..... Date of.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur?..... (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE..... DATE....., 19.....

Manner of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury.....

20. FILED..... 19..... Local Registrar.

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) C. C. G. [Signature], M. D.

(Address) [Address]

SUPPLEMENTARY

1941
1942
1943