

DEC. JAN 3 1938

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

42885
Do not use this space.

1. PLACE OF DEATH

(a) County Kansas Registration District No. 241
(b) Township N. Benton Primary Registration District No. 3-3-54
(c) City Buffalo (d) Street No. 4147 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

(a) Residence, No. 311 Wm J Stafford 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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs A. L. Stafford
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 13 1858
7. AGE YEARS 83 MONTHS 3 DAYS 11 If LESS than 1 day, hrs. or min.

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

12. BIRTHPLACE (CITY OR TOWN) Webster Co (STATE OR COUNTRY) Mo

FATHER 13. NAME Jack Stafford
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Lizzie Chapman
16. BIRTHPLACE (CITY OR TOWN) Mo (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Jack Stafford Buffalo Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 12-26-38

19. FUNERAL DIRECTOR (NAME) L. B. Jones (ADDRESS) Buffalo Mo

20. FILED 12/10 1938 Nancy Morrow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-24 1938
22. I HEREBY CERTIFY, That I attended deceased from 1935, to Dec-24, 1938.
I last saw him alive on Dec 20, 1938. Death is said to have occurred on the date stated above, at 9:30 a.m.
The principal cause of death and related causes of importance were as follows:

Uremia (Coma) Date of onset ?

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury
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? no
If so, specify (Signed) O. J. Gamm, M. D.
(Address) Buffalo Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

132

RECEIVED

District Health Officer No. 71
District File Number 7-39-18-9
Date Filed 1-16-39

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

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

42885-
Do not use this space.

1. PLACE OF DEATH *Dallas*

(a) County *Dallas* Registration District No. *241*

(b) Township *Buffalo* Primary Registration District No. *4147* Registered No. _____

(c) City *Buffalo* (d) Street No. _____ St. _____

(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 *Wm F Stafford*

(a) Residence, No. _____ St. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *m*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>83</i>	<i>3</i>	<i>11</i>	

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 _____

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

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

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

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 _____ *P. O. Damm* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-24-35*

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

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

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

Metabolic - Coma
Cardio-vascular-renal system
Chronic glomerulonephritis
Chronic hypertension

Date of onset *?*

Other contributory causes of importance: *12/1*
Prostatic hypertrophy

Name of operation *none* Date of _____

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
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? *no*
If so, specify _____
(Signed) *C. O. Gammow* M. D.
(Address) *Buffalo* *res*

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS PRESCRIBED BY LAW.

