

Registration District No. 743

Primary Registration District No. 1945

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ray
 (b) City or town Cricks
 (c) Name of hospital or institution: Home - Cricks, Mo.
 (If not in hospital or institution, write street number of location)
 (d) Length of stay: In hospital or institution 4 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
 (c) City or town Cricks
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME CLARENCE VINCENT SANDFORD

20. DATE OF DEATH: Month July day 23 year 1940 hour 6 minute P. M.

3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from July 1938, to July 23, 1940; that I last saw him alive on July 23, 1940 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 32 years

7. Birth date of deceased 4 (Month) 22 (Day) 1905 (Year)

Immediate cause of death _____

8. AGE: Years 35 Months 3 Days 23 If less than one day _____ hr. _____ min.

Duration _____
 Due to Coronary Occlusion

9. Birthplace Coffeyville Kansas (City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Merchant

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business Truste Dental Practice

PHYSICIAN _____

MOTHER FATHER { 12. Name George W. Sandford

Major findings: Of operations None

13. Birthplace Cole Co. Mo. (City, town, or county) (State or foreign country)

Of autopsy None

14. Maiden name Julia C. Hansen

Underline the cause to which death should be charged statistically

15. Birthplace St Charles Mo. (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following: _____

16. (a) Informant's own signature Marie (Doris) Sandford

(a) Accident, suicide, or homicide (specify) _____

(b) Address Cricks, Mo.

(b) Date of occurrence _____

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-23-40 (Month) (Day) (Year)

(c) Where did injury occur? _____ (City or town) (County) (State)

(c) Place: burial or cremation Smithtown Mo.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director McLaughlin Bros.

While at work? _____ (Specify type of place) (e) Means of injury _____

(b) Address Sedalia Mo.

23. Signature W. Campbell (M. D. or other) Mo.

19. (a) July 24, 1940 (Date received local registrar) (b) Belkison (Registrar's signature)

Address Cricks Date signed Mo.

WRITE PRINTED NAME OF DECEASED IN FULL IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. PHYSICIANS SHOULD STATE EXACTLY. 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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-16-40

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 R. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia, 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 this body is not embalmed, above space should be left blank.