

LED NOV 15 1940

Registration District No. 411

Primary Registration District No. 2002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Joplin  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. John's Hosptial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days) 13 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton  
(c) City or town R.R. # 1, Neosho, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. R. # 1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29  
year 1940 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from 25th  
October 1940, to October 28, 1940  
that I last saw her alive on October 28, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Tetanus  
Due to ?  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

2 wks

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:

Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
370  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Elmer H. [Signature] (M. D. or other) HA  
Address Joplin Mo Date signed 10/29

3. (a) PRINT FULL NAME MARY FRANCES STAFFORD

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased September 26, 1939  
(Month) (Day) (Year)

8. AGE: Years 1 Months 1 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Neosho, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Earl Stafford

13. Birthplace Kansas City, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Jean Legg

15. Birthplace Garfield, Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Stafford

(b) Address R.R. # 1 Neosho, Mo.

17. (a) Burial (b) Date thereof 10-30-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Saligman Cemetery

18. (a) Signature of funeral director Thornhill-Dillon

(b) Address Joplin, Missouri

19. (a) 10-29-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

22

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 Don Petrick

Licensed Embalmer No. 4008

P. O. Address Joplin, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 35569  
Registrar's No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 411

Primary Registration District No. 2002

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Jasper  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Mary Frances Stafford

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 1 3 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (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.

20. DATE OF DEATH Month Oct day 29 year 1950 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on..... and that death occurred on the date and hour stated above.  
Immediate cause of death

Due to Case unknown

Due to.....

Other conditions..... (Include pregnancy within 3 months of death) 22

Major findings:  
Of operations.....

Of autopsy.....

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

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

(b) Date of occurrence.....

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

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

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

23. Signature Stafford (M. D. or other).....

Address Jasper Mo Date signed 12/12

SUPPLEMENTAL ONLY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOORE

