

Registration District No. **801**

Primary Registration District No. **6044**

1. PLACE OF DEATH

(a) County **Saline Mo**
(b) City or town **Eastland Fresh Run**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3 mi W of Sweet Springs
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days) **80 yrs.**

3. (a) PRINT FULL NAME **JOSEPH A STAFFORD**

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

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **DIVORCED**

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

7. Birth date of deceased **MAR. 14 1853**
(Month) (Day) (Year)

8. AGE: Years **85** Months **6** Days **24** If less than one day hr. _____ min.

9. Birthplace **Winston Salem N. Car**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Retired**

MOTHER FATHER { 12. Name **Jesse Stafford**

18. Birthplace **N. Car**
(City, town, or county) (State or foreign country)

14. Maiden name **Mahalia Pitts**

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

16. (a) Informant **Robert Stafford**

(b) Address **Sweet Springs Mo**

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

(c) Place: burial or cremation **Home**

18. (a) Signature of funeral director **R. C. Carter**

(b) Address **Sweet Springs Mo**

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline**
(c) City or town **Rural, Eastland Fresh Run**
(If outside city or town limits write "RURAL")
(d) Street No. **3 mi W of Sweet Springs**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **9**
year **1940** hour **7** minute **P.** M.

21. I hereby certify that I attended the deceased from **Oct 14 1940**
19____ to **Oct 9** 19____

that I last saw him alive on **Oct - 9** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to _____

Due to _____

Other conditions: **940**
(Include pregnancy within 3 months of death)

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? _____

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

23. Signature **Chas. R. Parsons** (M. D. or other) **MD**

Address **Sweet Springs Mo** Date signed **10-10-40**

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

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-14-40

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. C. Carter*

Licensed Embalmer No..... *3513*

P. O. Address..... *Shut Springs 24/8*

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.