

1-10-39
17-39
X21492

FEB 25 1941

State File No. _____

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Phelps

(b) City or town Rolla (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps

(c) City or town Rolla (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME William J. Stafford

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2 year 1941 hour 8 minute P M.

4. Sex M **5. Color or race** W **6. (a) Single, widowed, married, divorced** Widowed

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

7. Birth date of deceased Aug 28, 1860 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June, 1934 to Jan 2, 1941; that I last saw him alive on Jan 2, 1941; and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months 7 Days 4 If less than one day _____ hr. _____ min.

Immediate cause of death Cerebral Hemorrhage Duration 1/2 / 1/4

Due to Hypertension 8-10

9. Birthplace Don't know (City, town, or county) (State or foreign country)

10. Usual occupation Retired

Due to Cardiovascular 4-5

Other conditions renal disease - acute degenerative

(Include pregnancy within 3 months of death)

11. Industry or business

12. Name Don't know

13. Birthplace Don't know (City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know (City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Norma Robinson

(b) Address Rolla Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Rolla Mo

18. (a) Signature of funeral director Rolla Mo

(b) Address _____

19. (a) Jan 5, 1941 (Date received local registrar) (b) Joe F. Myers (Registrar's signature)

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? 610

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

23. Signature Wm. C. ... (M. D. or other) 2

Address Rolla, Mo Date signed 1/4/40

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

RECEIVED

District Health Officer No. 5,

District File Number 241186

Date Filed _____

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 S. L. Reed
Licensed Embalmer No. 3394
P. O. Address Reed 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 3822

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Polla
(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

Wm J Stafford

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Aug 28 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-4-41 (b) Geo. F. Myers
(Water 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.

DEATH CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw h _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Wm Cottingham (M. D. or other) _____

Address Polla Mo Date signed _____

SUPPLEMENTARY

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

