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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 18 1941
893

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4753

Registration District No. 893

Primary Registration District No. 6195-a

Registrar's No. _____

1. PLACE OF DEATH
 (a) County Wayne
 (b) City or town Coldwater
 (If outside city or town limits, write "RURAL" and name of township)
Rural
 (If not in hospital or institution, write street number or location)
1
 (d) Length of stay: In hospital or institution _____
Life (Specify whether)

3. (a) PRINT FULL NAME James Thomas Gifford
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Male
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Corea Gifford
 6. (c) Age of husband or wife if alive 62 years
 7. Birth date of deceased: April 25 1873
 (Month) (Day) (Year)

8. AGE: Years _____ Months 9 Days 11
 If less than one day _____ hr. _____ min.
67

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

10. Usual occupation Farmer

11. Industry or business _____
 12. Name Payton Gifford
 13. Birthplace Tenn.
 (City, town, or county) (State or foreign country)
 14. Maiden name Fannie Barker
 15. Birthplace Tenn.
 (City, town, or county) (State or foreign country)

16. (a) Informant Tillog Gifford
 (b) Address Coldwater

17. (a) Burial (b) Date thereof Feb 16 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ballus Cemetery

18. (a) Signature of funeral director Ernest F. Frazier
 (b) Address Greenwood Ave

19. (a) 2-10 1941 (b) J. F. Pender
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Wayne
 (c) City or town Coldwater Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2 Miles North West of Coldwater
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 5 day _____
 year 1941 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from Jan 15 - 41
 _____, 19____, to Feb 5 - 1941
 that I last saw him alive on Feb 5 - 9:30 A.M.
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Liver
 Duration _____
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
815 (Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature Joe P. Wagner (M. D. or other) md
 Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

11
00

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

WAS NOT EMBALMED
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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4753

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 893

Primary Registration District No. 6185

Registrar's No.

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

1. PLACE OF DEATH:

(a) County... Wayne
(b) City or town... Caddo Creek
(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
In this community... (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Thomas Giffard

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. m

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

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

8. AGE: Years 67 Months 9 Days 11 If less than one day min.

9. Birthplace wayne la (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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2/6/41 (Date received local registrar) (b) J. F. Paulus (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 5 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him 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

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 John F. Wagner (M. D. or other)

Address Ascentville Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

