

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 7 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 375-

Registration District No. 71

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Excelsior Springs Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution yes (Specify whether years, months or days) 4 2/3 yrs. 7 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 510 Kansas City Ave  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAY SANFORD

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
(b) Name of husband or wife Geo. A. Sanford 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 17 1868  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Champaign Co, Ill. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Hotel operator

11. Industry or business \_\_\_\_\_  
12. Name E. J. Hill  
13. Birthplace Champaign Co, Ill. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Pamela C. Weary  
15. Birthplace Illinois 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ted Woods

(b) Address 510 Kansas City Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Excelsior Springs Community Hall

18. (a) Signature of funeral director Elizabeth Hope

(b) Address Excelsior Springs Mo

19. (a) 12-24-43 (Date received local Registrar) (b) Elizabeth Hope (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1943 hour 9 minute 25 P M.

21. I hereby certify that I attended the deceased from July 29 to Oct 22 1943 that I last saw him alive on Dec 22 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis etc

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Cerebral Accident  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 93d

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 E. J. Hill (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Date signed 12-23 1943

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

24

RECEIVED

District Health Officer No. 8,

District File Number

15-74-

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

*Virgil Hope*

Licensed Embalmer No. 3950

P. O. Address

*Excelsior Springs*

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.