

FILED JUL 7 1945

State File No.

Registration District No. 202

Primary Registration District No. 4319

Registrar's No. 77

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Andrew J. Wolford

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

(b) Name of husband or wife: Desire Stafford

6. (c) Age of husband or wife if alive: 76 years

7. Birth date of deceased: 2 (Month)

1 (Day) 1867 (Year)

8. AGE:

Years: 78 Months: 4 Days: 16 If less than one day hr. min.

9. Birthplace

James Marion MO (City, town or county) (State or foreign country)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER { 12. Name: G. B. Stafford Ky. 1  
13. Birthplace: Belle MO (City, town or county) (State or foreign country)  
14. Maiden name: James Marion MO  
15. Birthplace: MO (City, town or county) (State or foreign country)

16. (a) Informant

Desire Stafford

(b) Address

Liberty

17. (a) Burial

(Burial, cremation, or removal) Liberty Cemetery

(b) Date thereof

8-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation

Liberty Cemetery

18. (a) Signature of funeral director

Desire Stafford

(b) Address

Liberty

19. (a) Date received local registrar

6/19/45

(b) Registrar's signature

Ernest Bassett

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Marion  
(c) City or town: Belle (If outside city or town limits, write "RURAL")  
(d) Street No.: 0 (If rural, give location)  
(e) Citizen of foreign country? ✓ (Yes or No)  
If yes, name country: 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8  
year 1945 hour 12 minute a. M.

21. I hereby certify that I attended the deceased from Jan. 1945 to June 8 1945  
that I last saw him alive on June 7 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Cancer metastasis Duration

Due to: Cancer metastasis

Due to:

Other conditions: none  
(Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy: no 468

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

(a) Accident, suicide, or homicide (specify): no  
(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) (c) Means of injury

23. Signature: Dr. Jones (M. D. or other)  
Address: Belle MO Date signed: June 12/45

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

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed 7-6-45

APR 19 1951

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

working under my personal supervision.

Registered Apprentice No.

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.