

FILED DEC 26 1946

Registration District No. 96Primary Registration District No. 5354Registrar's No. 85

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town Rural
 (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

Mary Jane Stafford

3. (b) If veteran,

name war. no

3. (c) Social Security

No. no

4. Sex Female / 5. Color or white
 6. (a) Single, widowed, married, divorced widowed

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

alive _____ years

7. Birth date of deceased Nov 16 1962

(Month)

(Day)

(Year)

8. AGE: Years Months Days If less than one day

84127

_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Ben Highfill _____13. Birthplace Tenn _____ (City, town, or county) _____ (State or foreign country)14. Maiden name Lillian Mae _____15. Birthplace Unknown _____ (City, town, or county) _____ (State or foreign country)16. (a) Informant Ben Stafford _____(b) Address Red Top Mo.17. (a) Burial (b) Date thereof Dec 15 - 1946

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation Int. O. land.18. (a) Signature of funeral director W. Klingner & Co.(b) Address Springfield Missouri19. (a) Dec 20 1946 (b) Lucie Petrus

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dallas(c) City or town Rural (If outside city or town limits, write "RURAL")(d) Street No. Red Top Mo. (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13
year 1946 hour 5 minute 20 P.M.21. I hereby certify that I attended the deceased from from 12-12 1946, to 12-13 1946
that I last saw her alive on 12-13-46 and that death occurred on the date and hour stated above.Immediate cause of death Cerebral hemorrhage Duration 1 dayDue to Atherosclerosis & Hypertension yearsDue to Chronic Nephritis & C yearsOther conditions Old Coronary dis
(Include pregnancy within 3 months of death)Major findings: none 31B PHYSICIAN _____

Of operations _____

Of autopsy none _____

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 D23. Signature G. P. Plemmer (M. D. or other) M.D.Address Buffalo Mo. Date signed 12-14-46

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

97-2-21
ESTER-11-11

JAN 9 1947

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 Ogle Stone Jr.
Licensed Embalmer No. 4176
P. O. Address Springfield

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan 85
Registrar's No. _____

Registration District No. 96 Primary Registration District No. 5354

1. PLACE OF DEATH:

(a) County Dallas
 (b) City or town Rural
(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 years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary J. Stafford
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April, 1946 year, 13 hour, _____ minute. M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

4. Sex F 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 _____
 7. Birth date of deceased Nov 16 1886
(Month) (Day) (Year)

Duration _____

8. AGE: Years 84 Months _____ Days _____
(If less than one day hr. min.)

9. Birthplace _____
(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) _____ (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) 12-17-46 (b) Grace Peterson
(Date received local registrar) (Registrar's signature)

Due to _____

Due to _____

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

Major findings:
 Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

40074