

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Barksville  
(c) Name of hospital or institution: Laughlin Hospital  
(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)

3. (a) PRINT FULL NAME

A. I. Mefford

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 Cecil Mefford  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 26 1860  
(Month) (Day) (Year)

8. AGE: Years 86 Months 7 Days 15 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Wm Lee Cooley (Hosp Record)

(b) Address Barksville, Mo

17. (a) Removal (b) Date thereof Feb. 11, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shelbina, Missouri

18. (a) Signature of funeral director E. Hayes

(b) Address Shelbina, Mo.

19. (a) 2-11-47 (b) Wate Lambert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby  
(c) City or town Shelbina  
(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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1947 hour 10 minute 26 A. M.

21. I hereby certify that I attended the deceased from Feb 7 1947 to Feb 11 1947  
that I last saw him alive on Feb 11 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Prostatic Hypertrophy

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

Other conditions Marked capitis -  
(Include pregnancy within 3 months of death)

Major findings: old cardiac failure -  
Of operations ✓

Of autopsy ✓ 37A

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 2

23. Signature Carl Raiglen (M. D. or other) do

Address Barksville, Mo Date signed 3/1/47

RECEIVED  
District Health Officer No. 10  
District File Number 2: 41-382  
Date Filed FEB 21 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.....

Paul E. Hayes....., Registered Apprentice No. 417  
working under my personal supervision.

Signed.....Jack Hayes.....

Licensed Embalmer No. 3699

P. O. Address.....Sheehana, 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, fact should be so stated above.**

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March  
Registrar's No. 35

Registration District No. \_\_\_\_\_

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Winklesville  
(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 Al Mefford

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

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

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

9. Birthplace Marion County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Aaron Mefford  
13. Birthplace Kentucky  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director E Hayes  
(b) Address Shelburne

19. (a) 4-2-47 (b) Nate Lambert  
(Date 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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 11  
year 47 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 \_\_\_\_\_ Duration \_\_\_\_\_

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 \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

5-3822

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**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.....

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.**