

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11488

State File No.

 BIRTH NO. 49-026905 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 117

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Boone	b. CITY (If outside corporate limits, write RURAL and give township) Columbia	a. STATE Missouri	b. COUNTY Boone
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
		OR TOWN Columbia	
d. FULL NAME OF HOSPITAL OR INSTITUTION Boone County Hospital		d. STREET ADDRESS (If rural, give location) Route 6	

3. NAME OF DECEASED (Type or Print)	a. (First) STEPHEN	b. (Middle) WAYNE	c. (Last) HERIFORD	4. DATE OF DEATH (Month) (Day) (Year) May 3, 1949
-------------------------------------	------------------------------	-----------------------------	------------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May 3, 1949	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
-----------------------	----------------------------------	---	--	---------------------------------	---------------------------	-------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Columbia, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	---	---

13a. FATHER'S NAME Robert Heriford	13b. MOTHER'S MAIDEN NAME Donnie June Morgan	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Robert Heriford, Route 6, Columbia, Mo.	ADDRESS
---	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7.625
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Premature - 6-mo. DUE TO (c) ✓		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from May 3, 1949, to May 3, 1949, that I last saw the deceased alive on May 3, 1949, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H.C. Suggs M.D.	23b. ADDRESS Columbia, Mo.	23c. DATE SIGNED 5-4-49
--	--------------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 4, 1949	24c. NAME OF CEMETERY OR CREMATORY Columbia Cemetery	24d. LOCATION (City, town, or county) (State) Columbia, Mo.
--	---------------------------------	--	---

DATE REC'D BY LOCAL REG. May 4 1949	REGISTRAR'S SIGNATURE Mrs. R.E. Palmer	25. FUNERAL DIRECTOR'S SIGNATURE Parker Funeral Service	ADDRESS Columbia, Mo.
---	--	---	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

10
2
4

RECEIVED
District Health Officer No. 9,
District File Number
MAY 10 1949
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{Not} embalmed by me, or by _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed Tom McHarg _____

Licensed Embalmer No. 4067 _____

P. O. Address Columbia, 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.