

FILED AUG 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH23207
State File No. 182

BIRTH NO. _____		REG. DIST. NO. <u>137</u>		PRIMARY REG. DIST. NO. <u>3023</u>		Registrar's No. <u>182</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission).			
a. COUNTY <u>Henry</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>St. Clair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Clinton</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Osceola (Rural)</u>		93	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Watzel Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>near Damascus</u>			
3. NAME OF DECEASED		a. (First) <u>Josephine</u>		b. (Middle) <u>Gifford</u>		c. (Last) <u>Gifford</u>	
(Type or Print)						4. DATE OF DEATH (Month) (Day) (Year) <u>8-4-1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-20-1889</u>	
9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Shenandoah Ky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Mike Grant</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Chapman</u>		14. NAME OF HUSBAND OR WIFE <u>Major A. Gifford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Medea Gifford</u>		ADDRESS _____	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last... DUE TO (b) <u>Carcinoma of the</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS				171X	
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) (Min) _____		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 <u>Aug 27</u> , 1949, to <u>Aug. 3</u> , 1949, that I last saw the deceased alive on <u>Aug. 3</u> , 1949, and that death occurred at <u>1:30 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Chris L. Watzel</u>		23b. ADDRESS <u>Clinton</u>		23c. DATE SIGNED <u>8/4/1949</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/6/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah</u>		24d. LOCATION (City, town, or county) <u>Osceola Mo</u>	
DATE REC'D BY LOCAL REG. <u>Aug 6-49</u>		REGISTRAR'S SIGNATURE <u>Florence Adair</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Goodrich</u>		ADDRESS _____	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 71

District File Number 7-49-947

Date Filed 8-8-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

J. B. Goodrich

Signed _____
Student Embalmer

Licensed Embalmer No. 3038

P. O. Address Osses, 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.