

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 20185
Registrar's No. 44

BIRTH NO. _____		REG. DIST. NO. <u>4</u>		PRIMARY REG. DIST. NO. <u>5025</u>		Registrar's No. <u>44</u>									
1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>											
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural. Templeton Twsp</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural. Templeton Twsp.</u>											
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>				d. STREET ADDRESS (If rural, give location)											
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Gertrude</u>			b. (Middle) <u>Alice</u>			c. (Last) <u>Stanford</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 12 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>8 - 4 - 1880</u>		9. AGE (In years last birthday) <u>69</u>		10. MONTHS <u>1</u>		11. DAYS <u>8</u>		12. IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>Langdon, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>					
13a. FATHER'S NAME <u>Reason Wallace</u>				13b. MOTHER'S MAIDEN NAME <u>Abigail Spires.</u>				14. NAME OF HUSBAND OR WIFE <u>John Stanford.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John Stanford.</u>				ADDRESS <u>Rock Port. Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH			
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute heart failure.</u>								<u>30. Min.</u>			
				ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchial asthma.</u>								<u>6 Yrs.</u>			
				DUE TO (c)											
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								<u>241X</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>9/1/1949</u> , to <u>9/12/1949</u> , that I last saw the deceased alive on <u>9/11/1949</u> and that death occurred at <u>2 A.</u> m., from the causes and on the date stated above.															
23a. SIGNATURE <u>G.A. Reutter M.D.</u> (Degree or title)						23b. ADDRESS <u>Rockport, Mo.</u>			23c. DATE SIGNED <u>9/12/49</u>						
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			24b. DATE <u>9 - 14 1949</u>			24c. NAME OF CEMETERY OR CREMATORY <u>Hunter Cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>Rock Port; Mo.</u>						
DATE REC'D BY LOCAL REG. <u>9-13-49</u>			REGISTRAR'S SIGNATURE <u>Betty Crable</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>1</u>			ADDRESS <u>Bartholomew Mortuary ROCK PORT. MO.</u>						

(Licensed Embalmer's Statement on Reverse Side)

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



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.

Student
Student Embalmer

Signed Grady Barchalain

Licensed Embalmer No. #128 3173

P. O. Address Rock Port. 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.