

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44201

State File No.

FILED DEC 30 1952

BIRTH NO. REG. DIST. NO. 323 PRIMARY REG. DIST. NO. 4474 Registrar's No. 322

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SALINE</u>	
b. CITY OR TOWN <u>SWEET SPRINGS</u>		c. CITY OR TOWN <u>SWEET SPRINGS</u>	
c. LENGTH OF STAY (In this place) <u>ENTIRE LIFE</u>		d. STREET ADDRESS (If rural, give location) <u>102 NELSON</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>102 NELSON</u>			

3. NAME OF DECEASED (Type or Print) <u>ELIZABETH HAGAN STAFFORD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>DECEMBER-26-1952</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>MARCH 21-1863</u>	9. AGE (In years last birthday) <u>89</u>	10. IF UNDER 1 YEAR (Days) <u>9</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SWEET SPRINGS, MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>William Simmons Hagan</u>	13b. MOTHER'S MAIDEN NAME <u>ADALINE COFFEY</u>	14. NAME OF HUSBAND OR WIFE <u>FRANK STAFFORD</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. MONA TERRILL-MARSHALL</u> ADDRESS <u>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>arteriosclerotic heart disease</u>		DUPLICATE OF (a) <u>arteriosclerotic heart disease</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.		II. OTHER SIGNIFICANT CONDITIONS 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 Feb 1950, to 26 Dec 1952, that I last saw the deceased alive on 26 Dec 1952, and that death occurred at 5:45 AM, from the causes and on the date stated above.

23a. SIGNATURE <u>Ralph H Jones M.D.</u> (Degree or title)	23b. ADDRESS <u>Sweet Springs, Mo.</u>	23c. DATE SIGNED <u>27 Dec 52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>DECEMBER 28 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>FAIR VIEW Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>SWEET SPRINGS MO</u>		

DATE REC'D BY LOCAL REG. <u>12/27/52</u>	REGISTRAR'S SIGNATURE <u>Dolley Andrew</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L. F. Parker</u> ADDRESS <u>Sweet Springs, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

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

Student
Student Embalmer

Signed L. F. Parker

Licensed Embalmer No. 3840

P. O. Address Sweet Springs, 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.