

FILED JAN 23 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2061

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 5644 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY OR TOWN <u>Lexington</u>		c. CITY OR TOWN <u>Lexington</u> <u>Dover</u>	
c. LENGTH OF STAY (in this place) <u>Life</u>		d. STREET ADDRESS (If rural, give location) <u>2 blocks N. Hwy. 24</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Goodloe Rest Home</u>			

3. NAME OF DECEASED a. (First) <u>GARFEY</u> b. (Middle) <u>STANDFORD</u> c. (Last) <u>GODFREY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 10, 1953</u>		
(Type or Print) <u>GODFREY</u>					

5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>	8. DATE OF BIRTH <u>April 9 - 1884</u>	9. AGE (If years last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u>	IF UNDER 24 Hrs. Hours <u>0</u> Mins. <u>0</u>
--------------------	-------------------------------	---	--	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Higginville Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	---	---	--

13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Russ Stafford</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>Miss Jane Bolton</u> ADDRESS <u>6427 Valley KCMO</u>
---	------------------------------------	---

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	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)	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 January 10, 1953 to Jan 10, 1953 that I last saw the deceased alive on Jan 6, 1953 and that death occurred at 6 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. Rappaport MD</u> (Degree or Title)	23b. ADDRESS <u>Higginville Mo</u>	23c. DATE SIGNED <u>Jan 13-53</u>
---	------------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>January 13, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dover Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Dover Mo.</u>
---	-----------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>1-18-53</u>	REGISTRAR'S SIGNATURE <u>Missus E. Estabrook</u>	25. GENERAL DIRECTOR'S SIGNATURE <u>George H. Green</u> ADDRESS <u>Marshall Mo.</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

5540  
4  
100 MO  
-20-53

FEB 17 1953

JAN 23 1953

SEP 3 1954

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 George H. Brown

Licensed Embalmer No. 4220

P. O. Address Marshall, 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.