S. No. 300
v. 10-48

0280

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5270

State File No. .....

FILED MAR 13 1953 BIRTH NO. ____ REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 4151 Registrar's No. 5

1. PLACE OF DEATH
a. COUNTY: Crawford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Steelville
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri b. COUNTY: Crawford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Steelville 0280
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Preston b. (Middle) Peter c. (Last) Stanford

4. DATE OF DEATH: (Month) Feb. (Day) 12 (Year) 1953

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 7, 1880

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (City and State or Foreign Country): Scotia, Mo

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Samuel Stanford

13b. MOTHER'S MAIDEN NAME:

14. NAME OF HUSBAND OR WIFE: Christina Stanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS:

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility — Years
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: 4200

20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov 10, 1952, *to* Feb 9, 1953, *that I last saw the deceased alive on* Feb 8, 1953, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John L. Campbell M.D.

23b. ADDRESS: Steelville, Mo

23c. DATE SIGNED: 20 Feb 53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Feb. 15, 1953

24c. NAME OF CEMETERY OR CREMATORY: Fairview

24d. LOCATION (City, town, or county) (State): Butts Mo

DATE REC'D BY LOCAL REG.: 3/10/53

REGISTRAR'S SIGNATURE: [signature] 76-1

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Jonas Funeral Home Steelville Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Harry M. Jonas Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Harry M. Jonas

Licensed Embalmer No. 2628

P. O. Address Steelville, 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.