

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

636

State File No.

FILED FEB 15 1954

BIRTH NO. _____ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MO</u> b. COUNTY <u>Clinton</u>			
b. CITY OR TOWN <u>Cameron</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>Cameron</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>318 W 6th St</u>				e. STREET ADDRESS (If rural, give location) <u>318 W 6th St 02570</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Jefferson</u> c. (Last) <u>Hartford</u>			4. DATE OF DEATH (Month) <u>2</u> (Day) <u>4</u> (Year) <u>54</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov 18-1879</u>	
9. AGE (In years last birthday) <u>74</u>		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) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>De Kalb Co MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13a. FATHER'S NAME <u>James Canton Hartford</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Casar</u>			14. NAME OF HUSBAND OR WIFE <u>Maudie Hartford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>548-32-3386</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Maudie Hartford</u> ADDRESS <u>Cameron</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Edg</u>			
*This does not mean the mode of dying, such as heart failure, asphyxia, 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>hypertension</u>			
				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 <u>331X</u>				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) (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>7-1-</u> , 19 <u>47</u> , to <u>1-4-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>1-4-54</u> , 19 <u>54</u> , and that death occurred at <u>11:30</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. Moser, M.D.</u>				23b. ADDRESS <u>Cameron, MO</u>		23c. DATE SIGNED <u>2-6-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb-7-1954</u>		24c. NAME OF CEMETERY OR SREMATORY <u>Not Placed</u>		24d. LOCATION (City, town, or county) (State) <u>De Kalb Co MO</u>	
DATE REC'D BY LOCAL REG. <u>5-9-54</u>		REGISTRAR'S SIGNATURE <u>Winifred W. Moser</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Poland Funeral Home</u>		ADDRESS <u>Cameron</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.....
Signature of Student Embalmer

Signed.....
Robert F. Palmer

Licensed Embalmer No. *47*
2226
P. O. Address *Palmer*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.