

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1956

State File No. 3028  
Registrar's No. 45

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city of incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS 2729 Lucas		21 2729 Lucas	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2729 Lucas		f. (If rural, give location)		22 10	

3. NAME OF DECEASED (Type or Print) a. (First) Nevada b. (Middle) c. (Last) Stafford			4. DATE OF DEATH (Month) (Day) (Year) 1 - 2 - 56		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Feb. 7, 1914	9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Manchester, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Abe Stafford	13b. MOTHER'S MAIDEN NAME Camelia Hamm	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Harry Herman	ADDRESS 2815a N. Whitter
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Generalized Peritonitis. Caused by Ruptured Peps Salpinx (Due to Tubo Ovarian Abscess)		
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 10:39 a. m., from the causes and on the date stated above.

23a. SIGNATURE James M. Kelly	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 1-7-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1/5/56	24c. NAME OF CEMETERY OR CREMATORY Father Dickson	24d. LOCATION (City, town, or county) (State) St. Louis Co. MO
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DATE REC'D BY LOCAL REG. 1956 JAN 4	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry	ADDRESS 4202 Finney Ave
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Generic office states this was a tubal pregnancy. a.m. 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.....  
Signature of Student Embalmer

Signed *Melvin E. Green*.....

Licensed Embalmer No. *H. H. 2*.....

P. O. Address *St. Louis*.....

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.