

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
 FILED VS AUG 10 1959

**59-024789**

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 831

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>	Length of stay in 1b <u>5 WEEKS</u>	a. STATE <u>MO.</u>	b. COUNTY <u>WEBSTER</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>	c. CITY OR TOWN <u>SEYMOUR</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BURGE Hosp</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>GEORGE</u>	Middle <u>RUSSELL</u>	Last <u>MEFFORD</u>	Month <u>8</u>	Day <u>2</u>	Year <u>59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 18, 1894</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OZARK CO. MO.</u>	11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>MARION MEFFORD</u>	13b. MOTHER'S MAIDEN NAME <u>FRANCIS SCOFFIELD</u>	14. NAME OF HUSBAND OR WIFE <u>LORA MEFFORD</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>MRS. LORA MEFFORD SEYMOUR, MO</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
IMMEDIATE CAUSE (a) <u>Arteriosclerosis heart disease</u>	DUE TO (b)	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from 7-4-59 to 8-2-59 and last saw him alive on 8-1-59  
 Death occurred at 8:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Elmer M Powell MD</u>	22b. ADDRESS <u>609 Cherry, Springfield, Mo</u>	22c. DATE SIGNED <u>8-4-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR MASONIC CEMETERY</u>
23d. LOCATION (City, town, or county) <u>WEBSTER CO. MO.</u>	24. FUNERAL DIRECTOR <u>Robert Benjamin Seymour, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-5-59</u>
26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Max L Miller

Licensed Embalmer No. 472

P. O. Address Mansfield

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.