

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040516

FILED VS NOV 17 1959

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 501

LENDED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 1 year		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. San. & Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2326 Cedar		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELLA Middle HALLFORD Last				4. DATE OF DEATH Month November Day 10 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-27-1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Tifton, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William Aldridge			13b. MOTHER'S MAIDEN NAME Elizabeth Cranfield			14. NAME OF HUSBAND OR WIFE Jess Hallford, deceased		
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. None		17. INFORMANT Address Hazel Drake, 2326 Cedar, Indep., Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis & Embolism DUE TO (b) Fracture of hip DUE TO (c) 1 day - 10 days Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Parkinson's Disease 5 years						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) Fell in home						
20c. TIME OF INJURY Hour 10 a.m. / p.m. Month, Day, Year 10/27/59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		20f. CITY, TOWN OR LOCATION Independence		COUNTY Jackson	STATE MO	
21. I attended the deceased from 10/27/59 to 11/9/59 and last saw her 11/9/59 Death occurred at 11/10/59 m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Fred W. Link, MD (Degree or title)				22b. ADDRESS 10229 Independence Mo		22c. DATE SIGNED 11/10/59		
23a. BURIAL, CREMATION) REMOVAL (Specify) Removal		23b. DATE 11-10-59	23c. NAME OF CEMETERY OR CREMATORY Eldorado Springs Cemetery		23d. LOCATION (City, town, or county) (State) Eldorado Springs, Mo.			
24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson & Sons, Independence, Mo.			25. DATE RECD. BY LOCAL REG. 11-10-59		26. REGISTRAR'S SIGNATURE James Craig			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 3 1959

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.