

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010019

FILED VS MAR 28 1960

042

Primary Registration District No. 1000

Registrar's No. 373

STATE FILE NUMBER

INDEXED

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 31 years | | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1022 N. 9th St. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1022 N. 9th St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last STAFFORD | | | | 4. DATE OF DEATH Month March Day 21 Year 1960 | | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 3/22/1882 | 9. AGE (last birthday) 77 | 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) Ret. manager | | | 10b. KIND OF BUSINESS OR INDUSTRY Apartment House | | 11. BIRTHPLACE (City and state or country) Dearborn, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Benjamin Stafford | | | 13b. MOTHER'S MAIDEN NAME Agatha Brynat | | | 14. NAME OF HUSBAND OR WIFE Martha | | |
| 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 Address Mrs. Martha Stafford, 1022 N. 9th, St. Joseph, Mo. | | | |
| 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 | |
| IMMEDIATE CAUSE (a) Chr myocarditis | | | | | | | months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility. | | | | | | | yr | |
| DUE TO (c) Gen. arteriosclerosis | | | | | | | yr | |
| 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"/> N. <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.) | | | | | |
| 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 3-14-60 to 3-20-60 and last saw her/him alive on 3-14-60 Death occurred at 6:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) McGrimes MD | | | | 22b. ADDRESS St Joseph MO | | 22c. DATE SIGNED 3/22/60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 3/23/1960 | 23c. NAME OF CEMETERY OR CREMATORY Stafford Cemetery | | 23d. LOCATION (City, town, or county) (State) Dearborn, Mo. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Heston Bowman St. Joseph, Mo. | | | 25. DATE RECD. BY LOCAL REG. Mar. 24, 1960 | | 26. REGISTRAR'S SIGNATURE Wm Clark Goodell | | | |

DOCUMENT

M.E. Grimes, M.D. 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
or by Charles Deiss, Student Embalmer No. 604
working under my personal supervision.

Student Charles F. Deiss Jr.
Signature of Student Embalmer

Signed William Spalding

Licensed Embalmer No. 4535

P. O. Address P. O. Box 9

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.