URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-038083
STATE FILE NUMBER

LED VS NOV 7 1960 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1101

NDED

1. PLACE OF DEATH a. COUNTY: GREENE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MO. b. COUNTY: GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SPRINGFIELD — Length of stay in 1b:	c. CITY OR TOWN: SPRINGFIELD — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Burge Hospital — Inside Limits: Yes ☒ No ☐	d. STREET ADDRESS (If outside, give location): Rfd #2 Box 286 — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First: CHARLES	Middle: I.	Last: STAFFORD	4. DATE OF DEATH	Month: November Day: 1, Year: 1960
5. SEX: Male	6. COLOR OR RACE: White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 6 May 1887	9. AGE (last birthday): 73	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stock Dealer	10b. KIND OF BUSINESS OR INDUSTRY: Livestock	11. BIRTHPLACE (City and state or country): Missouri	12. CITIZEN OF WHAT COUNTRY: USA		
13a. FATHER'S NAME: Bird Stafford	13b. MOTHER'S MAIDEN NAME: Nancy Evans	14. NAME OF HUSBAND OR WIFE: Ruth Stafford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: Ruth Stafford(Wife) Address: Springfield, Mo. Rt.2			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Malignant Lymphoma, Reticulum Cell Type — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 8-31-60, to 11/1/60 and last saw her him alive on 10/31/60

Death occurred at 1:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. Simpson MD	22b. ADDRESS: 1630 N. Jefferson Springfield, Missouri	22c. DATE SIGNED: 11-2-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/4/60	23c. NAME OF CEMETERY OR CREMATORY: White Chapel Cemetery
23d. LOCATION (City, town, or county) (State): Springfield, Missouri		
24. FUNERAL DIRECTOR: KLINGNER MORTUARY, INC. ADDRESS: SPRINGFIELD MO.	25. DATE RECD. BY LOCAL REG.: 11-4-60	26. REGISTRAR'S SIGNATURE: Effie G. Wellon

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

NOV 7 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 417

P. O. Address SPRINGFIELD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.