SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-017186
STATE FILE NUMBER

AMENDED

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 76

FILED JUN 12 1961

1. PLACE OF DEATH
a. COUNTY Harrison
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bethany Mo - Length of stay in 1b 1 Day.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Nor Hospital Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Mo b. COUNTY Daviess
c. CITY OR TOWN Gallatin Inside Limits Yes ☒ No ☒
d. STREET ADDRESS (If outside, give location) Rural - Burton Twp. Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First James Middle Last STAFFORD

4. DATE OF DEATH Month June Day 1 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5/5/1877
9. AGE (last birthday) 84
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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Denver Co Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Erastus Stafford
13b. MOTHER'S MAIDEN NAME Nancy Messingill
14. NAME OF HUSBAND OR WIFE None

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. None
17. INFORMANT Mae Stafford Address Gallatin Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RIGHT CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC CEREBRAL VASCULAR DS. — years.
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 6-1-61, to 6-1-61 and last saw ~~him~~ him alive on 6-1-61
Death occurred at 9:23 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Albert Dikke (Degree or title) M.D.
22b. ADDRESS Bethany, Mo.
22c. DATE SIGNED 6-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4 June 61
23c. NAME OF CEMETERY OR CREMATORY Bethel
23d. LOCATION (City, town, or county) (State) Daviess Co. Missouri

24. FUNERAL DIRECTOR H. A. Robinson ADDRESS Gallatin Mo.
25. DATE RECD. BY LOCAL REG. 6-4-1961
26. REGISTRAR'S SIGNATURE Ella Maxey

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — DOCUMENT — SHOULD READ — BY AFFIDAVIT OF — ITEM NO.

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 5075

P. O. Address _____

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