

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022206

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 5166 Registrar's No. 154

FILED JUL 2 1962

VS 300	DATE AMENDED
Rev. 4/59	
6140	
30140	
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4 1	
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9422.1	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
10	
11	
1286-2	
13 1-0	
	INSTEAD OF
	MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Galloway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Calloway</u>	
b. CITY (If outside corporate limits, give township only) OR TOWN <u>Auxvasse Mo</u>		Length of stay in 1b <u>3 yrs</u>	c. CITY OR TOWN <u>Tebbetts Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Biggers Nursing Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. 2 W.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mayhaley</u> Middle <u>Stafford</u> Last <u>Stafford</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/64</u>
9. AGE (last birthday) <u>98</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Cato TENN</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Jessie Beasley</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. NAME OF HUSBAND OR WIFE <u>C.H. STAFFORD</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>NONE</u>	
18. INFORMANT <u>H.H. STAFFORD</u>		Address <u>Tebbetts Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General Senility</u>			
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		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 <u>Sept. 1960</u> to <u>June 28 62</u> and last saw her alive on <u>June 28 62</u> Death occurred at <u>1:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Auxvasse Mo</u>	
22c. DATE SIGNED <u>6-28-62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>JUNE 30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FARMER'S CORNE</u>	
23d. LOCATION (City, town, or county) <u>Near Tebbetts</u>		23e. STATE <u>MO</u>	
24. FUNERAL DIRECTOR <u>Clayton Sec. New Bloomfield Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 29-1962</u>	
26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield Mo

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.