

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-046075
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11692**

DO NOT WRITE ON THIS STUB
AMENDED

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USE BLACK INK OR TYPEWRITER RIBBON

FILED DEC 5 1963

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY JEFF

b. CITY (If outside corporate limits, give TOWNSHIP only) Length of stay in 1b
OR TOWN ST Louis

c. CITY OR TOWN DE SOTO Inside Limits Yes No

c. FULL NAME OF (IF NOT in hospital, give location) Hospital or Institution BARNES Hosp Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) Route #1 Yes No

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

4. DATE OF DEATH Month Day Year
Nov 25 1963

5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 7-30-29 9. AGE (last birthday) 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) St Louis, Mo

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME MANUEL D. LAWSON 13b. MOTHER'S MAIDEN NAME EDNA HALEY

14. NAME OF HUSBAND OR WIFE ROBERT STAFFORD

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. 17. INFORMANT Address ROBERT STAFFORD R#1 De Soto Mo

18. CAUSE OF DEATH (Enter only one cause per line from (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic renal disease INTERVAL BETWEEN ONSET AND DEATH 10 yrs.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Diabetes Mellitus 24 yrs.

DUE TO (c) 260x

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 11/11/49 to 11/25/63 and last saw her alive on 11/25/63
Death occurred at 1:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [Signature] M.D. 22b. ADDRESS BARNES HOSPITAL 22c. DATE SIGNED 11/26/63

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 11/28/63 23c. NAME OF CEMETERY OR CREMATORY O'MALLEY 23d. LOCATION (City, town, or county) (State) Edgar Springs Mo

24. FUNERAL DIRECTOR ADDRESS MAHN Funeral Home De Soto, Mo 25. DATE RECD. BY LOCAL REG. NOV 27 1963 26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

STATE OF MISSOURI

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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

Walter J. DeLoe

Licensed Embalmer No. 4995

P. O. Address DeLoe, 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.