

FILED MAR 3 1947

Registration District No. 354

Primary Registration District No. 4519

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Perry
(b) City or town Cabool
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 34 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas 107
(c) City or town Cabool, Mo. (If outside city or town limits, write "RURAL") 1
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Doctor Marian Wofford
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 14 year 1947 hour 12:30 minute _____ a.m.

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Addie Wofford 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 13 1870 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 7, 1947 to Jan 14, 1947 (that I last saw him alive on Jan 14 and that death occurred on the date and hour stated above.)
Immediate cause of death _____
Duration _____

8. AGE: Years 76 Months 6 Days 1 If less than one day _____ hr. _____ min.
9. Birthplace Unknown (City, town, or county) (State or foreign country) _____

Pulmonary fat embolism
fracture of head of femur
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation lumberman
11. Industry or business _____
12. Name Jack Wofford
13. Birthplace unknown (City, town, or county) (State or foreign country) _____
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) (State or foreign country) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Murna Coats
(b) Address Cabool, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Mo.
18. (a) Signature of funeral director G. J. Elliott
(b) Address Cabool, Mo.
19. (a) Feb 3 (Date received local registrar) (b) Raynell Cunningham (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____ 107
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature J. D. Russell (M. D. or other) 107
Address Cabool, Mo. Date signed 1/15/47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

24789
2-28-47

x 14

1000

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Licensed Embalmer No. 2252
P. O. Address.....

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 this body is not embalmed, fact should be so stated above.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH
(a) County Texas
(b) City or town Carbone
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Marion Wafford
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 76 Months _____ Days _____ If less than one year _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan year 1947 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.
Duration _____
Immediate cause of death _____

Due to _____

Due to trauma of femur

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Jan 3 - 1947

(c) Where did injury occur? Carroll, Texas, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In yard at home (Specify type of place)

While at work? _____ (c) Means of injury ice covered

23. Signature J. L. Brumley (M. D. or other) _____

Address Carroll, Mo Date signed 3/14/47

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-7613