

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042737

FILED VS NOV 20 1959

210250

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b 33 Yrs.	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION E/R to City Hosp.		d. STREET ADDRESS (If outside, give location) 2708 Armand Pl.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last George Ray Wolford	4. DATE OF DEATH Month Day Year Nov. 5, 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1905	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (City and state or country) Marshall, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME George Wolford	13b. MOTHER'S MAIDEN NAME Sadie Clemens	14. NAME OF HUSBAND OR WIFE Lena Wolford
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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. Yes (Unk)	17. INFORMANT Address Lena Wolford, 2708 Armand Pl.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis Due to (b) Coronary Sclerosis Due to (c) Cerebral Hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not given as the immediate cause) (d) etc. previous year		INTERVAL BETWEEN ONSET AND DEATH
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ on _____ the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Robert M. Duane</i>	22b. ADDRESS 1300 Cedar	22c. DATE SIGNED 11/9/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 9, 59	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette (4)	25. DATE RECD. BY LOCAL REG. NOV 9 1959	26. REGISTRAR'S SIGNATURE <i>Roald Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James R. Chapman

Licensed Embalmer No. 45

P. O. Address St. Louis

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.