

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022040

FILED VS. MAY 18 1960

340

Primary Registration District No. 6150

Registrar's No. 42

STATE FILE NUMBER

INDEXED

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Stoddard | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Leora New Lisbon Twp. | | Length of stay in 1b | | c. CITY OR TOWN Leora | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Store | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Vader Middle Wilfong Last Wilfong | | | | 4. DATE OF DEATH Month March Day 12 Year 1960 | | | | | |
| 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 3-21-1891 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months 11 Days 21 | 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 | | 11. BIRTHPLACE (City and state or country) Leora, Missouri | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Andrew Jackson Wilfong | | | 13b. MOTHER'S MAIDEN NAME Jennie Hayden | | | 14. NAME OF HUSBAND OR WIFE Hazel Wilfong | | | |
| 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. 487-18-6374 | | 17. INFORMANT Address Mrs. Hazel Wilfong, Leora, Mo. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 min | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Circulatory failure | | | | | | | 10 min | | |
| DUE TO (c) Coronary thrombosis | | | | | | | 1 hr | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes and Hypertension | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 Month, Day, Year | | | | | | | | | |
| 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 Aug 38 to Mar 12 60 and last saw him alive on Mar 12-60 Death occurred at 1:30 P. M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Deceased or title) L. A. Mustis | | | | 22b. ADDRESS Leora, Missouri | | | | 22c. DATE SIGNED 5-5-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-15-60 | 23c. NAME OF CEMETERY OR CREMATORY Leora | | 23d. LOCATION (City, town, or county) Leora, Missouri | | 23e. (State) | | |
| 24. FUNERAL DIRECTOR Strickland-Rainey | | | | ADDRESS Dexter, Mo. | | 25. DATE REC'D. BY LOCAL REG. 5/9/60 | | 26. REGISTRAR'S SIGNATURE Delmar V. Jenkins | |

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Guillermo Ramirez*
Licensed Embalmer No. 4983
P. O. Address: Dexter, Ga

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.