

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025845

FILED VS AUG 8 1960

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Primary Registration District No. 3006

Registrar's No. 441

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <i>Boone</i>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>	a. STATE <i>Missouri</i>	b. COUNTY <i>Boone</i>
Length of stay in 1b <i>9 days</i>		c. CITY OR TOWN <i>Centralia</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>University Medical Center</i>		d. STREET ADDRESS <i>At. 1, Centralia, Mo</i>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <i>Nancy</i>	Middle <i>Jean</i>	Last <i>Woolfolk</i>	4. DATE OF DEATH	Month <i>8</i>	Day <i>3</i>	Year <i>60</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>9-15-59</i>	9. AGE (last birthday) <i>10 mos.</i>	IF UNDER 1 YEAR Months <i>10</i> Days <i>19</i>	IF UNDER 24 HR Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Columbia, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Warren Woolfolk</i>	13b. MOTHER'S MAIDEN NAME <i>Mildred Cottrell</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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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) <i>no</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>University of Mo. Medical Center Hospital Chart</i>	Address <i>COLUMBIA, MO.</i>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<i>Hepatic Failure</i>	<i>9 mos</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	<i>Agenesis of Extrahepatic Biliary Tree</i>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>none</i>	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
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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.	Month, Day, Year
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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 *June 23, 1960* to *August 3, 1960* and last saw her/him alive on *Aug 3, 1960*
Death occurred at *4 55 P* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Roy August Westerfeld MD</i>	22b. ADDRESS <i>402 Stadium Road, Columbia, Mo</i>	22c. DATE SIGNED <i>Aug 3, 1960</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>Aug 6, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CITY OF CENTRALIA CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>MISSOURI</i>
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25. DATE RECD. BY LOCAL REG. <i>Aug 4-60</i>	26. REGISTRAR'S SIGNATURE <i>Mrs R E Palmer</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 9 1960

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

Lynnan Spunkle

Licensed Embalmer No. 4013

P. O. Address Columb

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.