16

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

33169

1. PLACE OF DEATH
County: Cape Gir Co
Township: Whitewater
City: Millersville
Registration District No. 124
Primary Registration District No. 5783
File No.
Registered No. 43
(No. ..... St. ..... Ward)

2. FULL NAME: John J. Wilforth
(a) Residence. No. Millersville St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Louisa Meyers Wilferth
6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 30 - 1844
7. AGE: Years 85 | Months 3 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: Dont know first name
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: J. F. Wilferth
(Address) Millersville Mo

15. FILED 10-12, 1929 D. G. Sisbee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 10th 1929
17. I HEREBY CERTIFY, That I attended deceased from Sept 30th, 1929, to Oct 10th, 1929 that I last saw him alive on Oct 9, 1929, and that death occurred, on the date stated above, at 7 A.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis (Hemiphlegia Right side)
820
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (SECONDARY): None
(duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At home
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
(Signed) D. J. L. Sigbeigh, M.D
10-12, 1929 (Address) Jackson Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Miller Cemetery
DATE OF BURIAL: 10-13 1929
20. UNDERTAKER: Crocraft & Miller
ADDRESS: Jackson

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.