

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

29931  
Do not use this space.

REC'D SEP 19 1939

1. PLACE OF DEATH  
 (a) County Phelps Registration District No. 677  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4403  
 (c) City Rolla (d) Street No. Rolla Hospital Registered No. 95  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Blanch Comer Wofford  
 (a) Residence, No. Star Point Belle, Mo St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF Clay Wofford

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 17, 1900

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
<u>46</u>	<u>10</u>	<u>11</u>		

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osage Co. Mo

FATHER

13. NAME W. A. Walker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

MOTHER

15. MAIDEN NAME Elizabeth Brandon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT Clay Wofford  
 (ADDRESS) Star Point Belle Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Belle Mo DATE Aug 30 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. L. Licklider  
Belle, Mo

20. FILED Aug 29 1939 Joe F. Ayers Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-24 1939, to 8-29 1939. I last saw h.c.h. alive on 8-29 1939. Death is said to have occurred on the date stated above, at 4:25 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Pall Stomach and Appendicitis  
 Date of onset 12/1

Other contributory causes of importance: \_\_\_\_\_

Name of operation Appendectomy and gall bladder  
 What test confirmed diagnosis? Drainage Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) W. L. Licklider M.D.  
 (Address) Rolla Mo

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.

**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.

District Health Officer No. 5,

Signed .....

District File Number 439224

Licensed Embalmer No. ....

Date Filed 9-13-39

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, above space should be left blank.**