

FILED JAN 13 1943

Registration District No. _____

Primary Registration District No. **3000**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Franksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 1/2** days
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Franksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **County Farm**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Wolford, J. C.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 31 1855**
(Month) (Day) (Year)

8. AGE: Years **87** Months **6** Days **28** If less than one day _____ hr. _____ min.

9. Birthplace **Columbus Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Do not know**

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Gertrude Larsson**

(b) Address **Rural Ill.**

17. (a) **Rural** (b) Date thereof **12/28/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Stanford Ill.**

18. (a) Signature of funeral director **Dan Fernald**

(b) Address **Franksville Mo.**

19. (a) **12/28/42** (b) **Mrs. J. P. Wagner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **28**
year **1942** hour **5** minute **45** A. M.

21. I hereby certify that I attended the deceased from **7/1/42**
19____ to **12/28/42** 19____

that I last saw ~~him~~ **her** alive on **12/27/42** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic De-compensation**

Due to **sterility**

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations **95c**

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Cotter P. Boney** (M.D. or other) **MD**

Address **Franksville, Mo.** Date signed **12/28/42**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File No. 10-43-81
Date Filed JAN 11 1943

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.

Signed..... Keith Collier
Licensed Embalmer No. 3632
P. O. Address Yubsville MO

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, fact should be so stated above.