S. No. 2
I—9-4-41
. 5-17-39
PI X29484

DEPARTMENT OF COMMERCE FILED FEB 2 1943
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3180

FILED FEB 2 1943

Registration District No. 290 Primary Registration District No. 5983 Registrar's No. (3) 12

85
0
0

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Fort Leonard Wood, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Station Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community 19 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999
(a) State New York (b) County Nassau 30
(c) City or town Bethpage 0
(If outside city or town limits, write "RURAL")
(d) Street No. Wantagh Ave., Box 58
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME GEORGE T. WILLFORD (Pvt)
3. (b) If veteran, name war — — — 3. (c) Social Security No. — — —

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased October (Month) 25 (Day) 1910 (Year)

8. AGE: Years	Months	Days	If less than one day
32	2	16	hr. min.

9. Birthplace Newark (City, town, or county) New Jersey (State or foreign country)
10. Usual occupation Soldier-U.S.Army-32681896
11. Industry or business Co D, 28th ERTC Bn.
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant U. S. Army Records
(b) Address Fort Leonard Wood, Missouri
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/12/43 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director [signature]
(b) Address Rolla, Mo.
19. (a) Jan. 11, 1943 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10 year 1943 hour 7 minute 50 P. M.
21. I hereby certify that I attended the deceased from .... 19...., to .... 19....;
that I last saw h.... alive on .... 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Shock (Clinical)	12 hrs
Due to (1) Hemorrhage into the adrenal cortex, bilateral.	— —
Due to (2) Idiopathic purpura hemorrhagica.	18 hrs

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Howard A. [signature] (M. D. or other)
Address Date signed

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

1170 1-15-43

(Licensed Embalmer's Statement on Reverse Side)

FEB 2 1943

RECEIVED
Pulaski County Health Officer
File Number 1-43-8
Date Filed 1-29-43

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 S. L. Russell

Licensed Embalmer No. 339

P. O. Address Rolla 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.

. No. 2
—9-4-41
5-17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3180

Registration District No. 296 | Primary Registration District No. 5983 | Registrar's No. 12

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME GEORGE T. WILLFORD
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October (Month) 25 (Day) 1910 (Year)

8. AGE: Years 32 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace (City, town, or county) New Jersey (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10
year 1943 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Shock (clinical)	12 hrs
Due to (1) Hemorrhage into the adrenal cortex, bilateral.	
Due to (2) Purpura hemorrhagica due to meningococcemia, epidemic cerebro-spinal type.	18 hrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence No
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Howard A. Stellar (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.