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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 14 1944
Registration District No. 224

Primary Registration District No. 6093

Registrar's No. 49

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(c) Name of hospital or institution Saline County Home
(d) Length of stay: In hospital or institution about 6 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Slater
(d) Street No. 1
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Peter Thornton Wolford
(b) If veteran, name war Civil War
(c) Social Security No. [check]

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 19 year 1944 hour minute M.

4. Sex M 5. Color or race wh
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

21. I hereby certify that I attended the deceased from Nov 1 1943 to Feb 19 1944 that I last saw him alive on Feb 17 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 99 Months 1 Days 0 If less than one day hr. min.

Immediate cause of death: Degenerative pneumonia
Due to: General weakness from senility

9. Birthplace Saline Co Mo
10. Usual occupation Farmer

Other conditions: [check]
Major findings: Of operations [check]
Of autopsy [check]

MOTHER FATHER

11. Industry or business Retired
12. Name George Wolford
13. Birthplace Va
14. Maiden name Taylor
15. Birthplace [check]
16. (a) Informant G. M. Wolford
(b) Address Slater Mo
17. (a) Burial (b) Date thereof 2-22-44
(c) Place: burial or cremation Slater Mo
18. (a) Signature of funeral director Hill Brothers
(b) Address Slater Mo
19. (a) Date received local registrar 2-24-44 (b) Registrar's signature mo J. Oleschinski

PHYSICIAN [Signature]
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?
(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 [Signature] (M. D. or other) Address [Signature] Date signed 2/24/44

RECEIVED

District Health Officer No. 8,

District File Number

3-13-44

Date Filed

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... *Sam M Hill*

Licensed Embalmer No. *1292*

P. O. Address... *Slater 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.