

FILED NOV 28 1947

Registration District No. 32

Primary Registration District No. 4044

1. PLACE OF DEATH:

(a) County Bellinger
(b) City or town Wray, Wayne Twp
(c) Name of hospital or institution Shell Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 (Specify whether)
In this community 3 months years, months or days

3. (a) PRINT FULL NAME

ISAAC WILFONG

3. (b) If veteran,

name war none

3. (c) Social Security

No. none

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife Sarah Ann Wilfong 6. (c) Age of husband or wife if alive 88 years
7. Birth date of deceased Dec 4, 1958 (Month) (Day) (Year)

8. AGE: Years 88 Months 11 Days 0 If less than one day hr. min.

9. Birthplace Ripley Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Stuffer Wilfong

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

14. Maiden name not known

15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant Harrison Wilfong

(b) Address Advance, Mo

17. (a) Burial (b) Date thereof Nov 6, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Advance, Mo

18. (a) Signature of funeral director Walter S. Morgan

(b) Address Advance, Mo

19. (a) Nov 21, 47 (b) Willie Y. VanAntwerp (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6 year 1947 hour 7 minute 0 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on 11/1/47 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomposition

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 95

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 95
Signature John J. Myers (M.D. or other) Dr
Address South Gate Mo Date signed 11/7/47

RECEIVED

District Health Officer No. 4
District File Number 1147-1486
Date Filed 11-26-47

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 _____

Floyd S. Morgan, Jr., Registered Apprentice No. 430
working under my personal supervision.

Signed Floyd S. Morgan

Licensed Embalmer No. 3361

P. O. Address Advance, 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.