

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 21 1959/60

59-025724

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 559 Registrar's No. 99

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u> (DOA) b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Joachim Township</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jefferson Memorial Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residency before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN <u>Festus,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>405 Sunshine Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Danny E. Wilfong</u>			4. DATE OF DEATH Month Day Year <u>6-28-59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-1951</u>	9. AGE (last birthday) <u>7</u>	IF UNDER 1 YEAR IF UNDER 24 MONTHS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>BOYNE JERRE, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>HAROLD E WILFONG</u>		13b. MOTHER'S MAIDEN NAME <u>MARY HOWELL</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HAROLD E WILFONG Festus</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>typhoid respiratory infection</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral palsy</u>				PART III. If deceased was female there a pregnancy in last 90 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unkn	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from <u>Jan. 7, 59</u> to <u>June 28, 59</u> and last saw her/him alive on <u>June 27, 59</u> Death occurred at <u>9:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. Charles Dejean, M.D.</u>			22b. ADDRESS <u>Festus, Mo</u>		22c. DATE SIGNATURE <u>6/29/59</u>
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City, town, or county) (State) <u>Leadington Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>P. Caldwell, son</u>		25. DATE RECD. BY LOCAL REG. <u>7-9-59</u>	26. REGISTRAR'S SIGNATURE <u>James G. Fisher</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Bertalan Bolgar, M.D.

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. Caldwell

Licensed Embalmer No. 2531

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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