URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 15 1960

60-007821
STATE FILE NUMBER

ENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 100

1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre, Mo — Length of stay in 1b: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY St. Francois
c. CITY OR TOWN Flat River, Mo. — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 206 Crane St — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Cecil Middle: Earl Last: Williford
4. DATE OF DEATH Month: March Day: 9 Year: 1960
5. SEX: male
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11/7/31
9. AGE (last birthday): 28
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bricklayer
10b. KIND OF BUSINESS OR INDUSTRY: brick setting
11. BIRTHPLACE (City and state or country): Bruce, Mississippi
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Cecil R. Williford
13b. MOTHER'S MAIDEN NAME: Bertie Thomas
14. NAME ~~OF HUSBAND OR~~ WIFE: Martha Jean (Norwood) Williford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 409-38-7868
17. INFORMANT: mother — Address: 206 Crane St. Flat River, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage → INTERVAL BETWEEN ONSET AND DEATH: 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Spinal Cord injury c̄ apparent
DUE TO (c): transection of Cord → 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Quadriplegia for 3 years following injury.
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1957, to March 9, 1960 and last saw ~~her~~ him alive on March 8, 1960
Death occurred at 2:00 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. L. Foster (Degree or title) MD
22b. ADDRESS Desloge, Mo
22c. DATE SIGNED March 9, 60

23a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) BURIAL
23b. DATE 3/11/60
23c. NAME OF CEMETERY OR ~~CREMATORY~~ Bruce Cemetery
23d. LOCATION (City, town, or county) (State) Bruce, Mississippi
24. FUNERAL DIRECTOR Alvin W. Hood, ADDRESS Flat River, Mo.
25. DATE RECD. BY LOCAL REG. March 10, 1960
26. REGISTRAR'S SIGNATURE Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student._____ Signed Albert W. Hood

Signature of Student Embalmer

Licensed Embalmer No. 2780

P. O. Address Alex Ru

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.