

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017634

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1162 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 27 1962

VS 300
Rev. 4/59

4403
20940

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST. LOUIS COUNTY</u>	a. STATE <u>MO.</u>	b. COUNTY <u>ST. FRANCIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD, MO</u>	Length of stay in lb <u>3 DAYS</u>	c. CITY OR TOWN <u>FLUINS, MISSOURI</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hosp.</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>Billy Joe WOFFORD</u>		Month Day Year <u>APRIL 11, 1962</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>JAN 22, 1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (City and state or country) <u>FLUINS, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>CLIFFORD WOFFORD</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA BOWEN</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		17. INFORMANT <u>MR. CLIFFORD WOFFORD</u>	Address <u>ELUINS</u>
18. CAUSE OF DEATH (Enter only one cause per line)			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)			<u>Head Injury, Severe, to Brain Stem Injury 3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>DRIVER OF AUTO SLIDE INTO ANOTHER CAR</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>11 A. 4-8-62</u>	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 COUNTY STATE
21. I attended the deceased from <u>April 8, 1962</u> to <u>April 11, 1962</u> and last saw her/him alive on <u>April 11, 1962</u>		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Grant A. Palazzo MD</u>		22b. ADDRESS <u>4161 Lindell, St. Louis, Mo.</u>	22c. DATE SIGNED <u>4-12-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4/14/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MATTIE ROBERT</u>	23d. LOCATION (City, town, or county) (State) <u>FARMINGTON, MO</u>
24. FUNERAL DIRECTOR <u>R. HALC Well & Sons</u>		25. DATE RECD. BY LOCAL REG. <u>4-12-62</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy MD.</u>

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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 DONALD DALE LALWELL

Licensed Embalmer No. 5095

P. O. Address FLAT RIVER, MD

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.

JAN 1967