

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27511**

FILED SEP 13 1951

2542
0

BIRTH NO. _____ REG. DIST. NO. **174** PRIMARY REG. DIST. NO. **3035** Registrar's No. **100**

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Lafayette | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lexington | |
| c. LENGTH OF STAY (in this place) about 5 minutes | | d. STREET ADDRESS (If rural, give location) 1719 South Street | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DeLyngton Memorial Hospital | | | |

| | | | | |
|-------------------------------------|-------------------------|--------------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) WILLA | b. (Middle) ALICE | c. (Last) WILSON | 4. DATE OF DEATH (Month) (Day) (Year) September 6 1951 |
|-------------------------------------|-------------------------|--------------------------|-------------------------|---|

| | | | | | | |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 29, 1889 | 9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months 2 Days 7 Hours Min. | IF UNDER 1 YEAR Hours Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|---|---|

| | | | |
|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Lexington, Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|---|--|--|

| | | |
|---|--|---|
| 13a. FATHER'S NAME Willa V. Curtis | 13b. MOTHER'S MAIDEN NAME Alice Kelly | 14. NAME OF HUSBAND OR WIFE Jeff R. Wilson |
|---|--|---|

| | | |
|--|-------------------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT'S SIGNATURE OR NAME Jeff Wilson ADDRESS Lexington, Missouri |
|--|-------------------------------------|---|

| | | | |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion in the heart | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION No operation | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|

| | | |
|--|---|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) No | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|---|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **after death** to _____, 19____, that I last saw the deceased alive on **9-6**, 19**51**, and that death occurred at **9:45** m., from the causes and on the date stated above.

| | | |
|--|-------------------------------|--------------------------------|
| 23a. SIGNATURE W. Martin MD Coroner (Degree or title) | 23b. ADDRESS O Chase M | 23c. DATE SIGNED 9-7-51 |
|--|-------------------------------|--------------------------------|

| | | | |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | 24b. DATE Sept. 9-51 | 24c. NAME OF CEMETERY OR CREMATORY machpelah | 24d. LOCATION (City, town, or county) (State) Lexington, Missouri |
|---|-----------------------------|---|--|

| | | |
|---|--|--|
| DATE REC'D BY LOCAL REG. Sept. 10 - 1951 | REGISTRAR'S SIGNATURE William S. S. [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE Forest [Signature] ADDRESS DeLyngton Memorial |
|---|--|--|

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

RECEIVED

9-12-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 9-12-51 _____

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 _____

Thomas H. Brown

working under my personal supervision.

Student Embalmer No. 427

Signed *Thomas H. Brown*
Student Embalmer

Signed *L. M. Keane*

Licensed Embalmer No. 2983

P. O. Address *Livingston, Missouri*

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.