

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11860**

FILED MAR 24 1952

BIRTH NO. _____ REG. DIST. NO. **375** PRIMARY REG. DIST. NO. **6281** Registrar's No. **13**

1. PLACE OF DEATH a. CITY Wright		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Wright	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Rural Van Buren		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Van Buren Twp 1140	
c. LENGTH OF STAY (In this place) 88 Yrs		d. STREET ADDRESS (If rural, give location) 2 Miles South Manes, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Emily	b. (Middle) Drewsilla	c. (Last) Willhite	4. DATE OF DEATH (Month) (Day) (Year) 2 28 1952
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5. SEX F	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2	8. DATE OF BIRTH 1-10-1864	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 1 Days 18	IF UNDER 6 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Wright County, Mo 0	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Jeff Wilds	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE G. W. Willhite
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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 John Willhite, Manes, Mo.	ADDRESS
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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, assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Not known
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis, Chronic		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio Renal syndrome 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 442X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **6-10, 1951**, to **2-28, 1952**, that I last saw the deceased alive on **2-27, 1952**, and that death occurred at **2:55A m.**, from the causes and on the date stated above.

23a. SIGNATURE Adl Cooney M.D. (Degree or title)	23b. ADDRESS Mountain Gap, Mo	23c. DATE SIGNED 15 March 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 22-29-1952	24c. NAME OF CEMETERY OR CREMATORY Green Mtn. Cem	24d. LOCATION (City, town, or county) (State) Wright County, Mo.
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DATE REC'D BY LOCAL REG. 3-21-52	REGISTRAR'S SIGNATURE Ed Garner 346	25. FUNERAL DIRECTOR'S SIGNATURE Gene E. Halder ADDRESS Fayetteville, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

WRIGHT CO. HEALTH DEPT.
County File Number 38-2-38
Date Filed 3-22-22

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
Student Embalmer

Signed Gene E. Zalden

Licensed Embalmer No. 3865

P. O. Address Hartsville, 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.