

FILED JUL 14 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18123

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>3007</u>		Registrar's No. <u>384</u>	
1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>STODDARD</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>POPLAR BLUFF</u>		c. LENGTH OF STAY (in this place) <u>9 DAYS</u>		c. CITY OR TOWN <u>DUDLEY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>DOCTORS HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>IN DUDLEY 1030</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MISSOURI</u>		b. (Middle) <u>SUSAN</u>		c. (Last) <u>WILSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-23-1954</u>	
5. SEX <u>FEMALE</u>		6. COLOR OF RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>6-20-1895</u>	
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____		11. BIRTHPLACE (City and State or Foreign Country) <u>MISSOURI</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY ----- DUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH C. BARTON</u>			13b. MOTHER'S MAIDEN NAME <u>KATHLEEN MC WILLAN</u>			14. NAME OF HUSBAND OR WIFE <u>IRA WILSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>J.F. POWELL</u>		ADDRESS <u>BERKLEY MICH.</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>My persistent cardiovascular disease.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic glomerulonephritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		20. AUTOPSY? <u>592 X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <u>6-14, 1954</u> , to <u>June 23, 1954</u> , that I last saw the deceased alive on <u>June 23, 1954</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert Chubbard MD</u>				23b. ADDRESS <u>Poplar Bluff, Mo</u>		23c. DATE SIGNED <u>June 28, 1954</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>6-25-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>DUDLEY</u>		24d. LOCATION (City, town, or county) (State) <u>STODDARD COUNTY MO.</u>	
DATE REC'D BY LOCAL REG. <u>7/7/54</u>		REGISTRAR'S SIGNATURE <u>R.H. Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. White</u>		ADDRESS <u>Fisk, Mo.</u>	

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

RECEIVED

JUL 17 1954

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

JUL 9 1954

JUL 20 1954

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~~ ..... 6-23-54 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... Phil A. Leuchel .....

Licensed Embalmer No. 290.....

P. O. Address..... Caplan B .....

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.