

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41654

State File No.

FILED JAN 3 1955

BIRTH NO. REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3080 Registrar's No. 22

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

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Macon 0611	
d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hospital		d. STREET ADDRESS (If rural, give location) 614 Broadway 0	
3. NAME OF DECEASED (Type or Print) a. (First) SHERRY b. (Middle) JEAN c. (Last) WILSON			4. DATE OF DEATH (Month) (Day) (Year) 12 16 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 23, 1944
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 11
11. BIRTHPLACE (State or foreign country) Trenton, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James H. Wilson		13b. MOTHER'S MAIDEN NAME Dorthy Jean Fair	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James H. Wilson Macon, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema 3 hours DUE TO (b) Acute Myocardial Failure 10 hours DUE TO (c) Chronic Glomerulonephritis 2 years II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION NO		19b. MAJOR FINDINGS OF OPERATION NO	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 592 X
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)
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 5 MAY, 1954, to 17 DEC, 1954, that I last saw the deceased alive on 17 DEC, 1954, and that death occurred at 10:20 A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. H. Martin MO		23b. ADDRESS Chillicothe, MO	23c. DATE SIGNED 18 DEC 54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 18, 1954	24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial	24d. LOCATION (City, town, or county) (State) Macon, MO.
DATE REC'D BY LOCAL REG. 12-28-54	REGISTRAR'S SIGNATURE Frances B. Neill	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. Leslie Gram Macon, Mo.	

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 R. Leslie Brown

Licensed Embalmer No. 4472

P. O. Address Milwaukee, Wis.

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.