

FILED NOV 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39054

State File No. 9872

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Barry					
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Washburn		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) Rural Route					
3. NAME OF DECEASED (Type or Print) a. (First) Dorothy b. (Middle) NMN c. (Last) Wilson			4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1955						
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED (Specify) married		8. DATE OF BIRTH 11-22-1907			
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Washburn, Mo.			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Black		13b. MOTHER'S MAIDEN NAME Flora unknown		14. NAME OF HUSBAND OR WIFE William Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Wm. Wilson, Washburn, Mo. ADDRESS _____					
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) Sub-arachnoid Hemorrhage ANTECEDENT CAUSES DUE TO (b) Intercranial Aneurysm 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	
19a. DATE OF OPERATION 11/9/55		19b. MAJOR FINDINGS OF OPERATION As above				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) 330X					
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 Oct. 31, 1955 , to Nov. 11, 1955 , that I last saw the deceased alive on Nov. 11, 1955 , and that death occurred at 5:05A.M. , from the causes and on the date stated above.									
23a. SIGNATURE [Signature] (Degree or title) M.D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 11/11/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 11-11-55		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Cassville, Mo.			
DATE REC'D BY LOCAL REG. NOV 14 1955		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Culver, Cassville, Mo. ADDRESS _____					

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

STATEMENT BY LICENSED EMBALMER

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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.....
Beutzel

Licensed Embalmer No. *111*

P. O. Address *1111*

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.