

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30155**

FILED OCT 15 1956  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 91 PRIMARY REG. DIST. NO. 3012 Registrar's No. 93

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CLAY</u>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>EXCELSIOR SPRINGS, MO</u>       | c. LENGTH OF STAY (In this place) <u>5 DAYS</u> | c. CITY OR TOWN <u>EXCELSIOR SPRINGS</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 HOSPITAL OR INSTITUTION <u>EXCELSIOR SPRINGS HOSPITAL</u><br>STREET ADDRESS <u>608 S2 LOUIS</u> |   |  |   |

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|--|--|--|---|--|
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>WILSON</u> b. (Middle) <u>JOSEPH</u> c. (Last) <u>CECIL</u> |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT 30 1956</u> |  |
|--|--|--|---|--|

|                    |                               |   |  |   |   |   |
|--------------------|-------------------------------|---|--|---|---|---|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>MARCH 17, 1886</u> | 9. AGE (In years last birthday) <u>70</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
|--------------------|-------------------------------|---|--|---|---|---|

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUGGIST</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>DRUG STORE</u> |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>WINDSOR MISSOURI</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |
|---|--|---|--|--|--|---|--|

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME <u>JOHN P. CECIL</u> |  | 13b. MOTHER'S MAIDEN NAME <u>EFFIE GRAY</u> |  | 14. NAME OF HUSBAND OR WIFE <u>LUCILE NICKEL</u> |  |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>491-01-8365</u> | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS WILSON CECIL, EX SPRINGS, MO</u> |  |  |  |
|---|--|---|--|--|--|

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|--|--|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>  |  | DUE TO (b) <u>hypertension</u>  |  |  | sev. yrs. <u></u>                              |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |

|                        |  |  |  |  |  |
|------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>331X</u> |  |  | 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) |  |
|--|--|--|---|--|

|  |  |  |  |  |                            |
|--|--|--|--|--|----------------------------|
| 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? |
|--|--|--|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 9/24, 1956, to 9/30, 1956, that I last saw the deceased alive on 9/30, 1956, and that death occurred at 1:30A m., from the causes and on the date stated above.

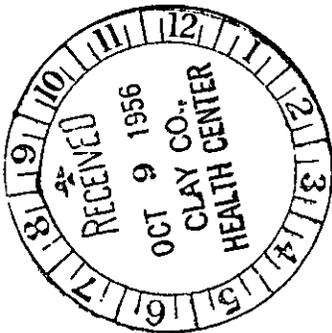
|  |  |  |  |                                 |
|--|--|--|--|---------------------------------|
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u> |  | 23b. ADDRESS <u>Excelsior Springs, Mo.</u> |  | 23c. DATE SIGNED <u>10/3/56</u> |
|--|--|--|--|---------------------------------|

|   |                              |  |  |  |
|---|------------------------------|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>OCT 2, 1956</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>MASONIC CEMETERY</u> | 24d. LOCATION (City, town, or county) (State) <u>EXCELSIOR SPRINGS, MO</u> |  |
|---|------------------------------|--|--|--|

|   |   |  |  |  |
|---|---|--|--|--|
| DATE REC'D BY LOCAL REG. <u>10-3-56</u> | REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Richard Funeral Home, Inc. Excelsior Springs, Missouri</u> |  |  |
|---|---|--|--|--|

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

620



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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 *A* .....  
Signature of Student Embalmer

Signed *Lindell Jarman* .....

Licensed Embalmer No. *4589*  
P. O. Address *Excelsior Springs, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.