

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40692

STATE FILE NUMBER

FILED DEC 17 1956

85451-56 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1311

Health, Welfare, Public Service

300 8-56

Dr. Matherhead  
DISEASES IN PART I MUST BE CASUALLY RELATED. CORONER CANNOT CERTIFY TO A DEATH DUE TO NATURAL CAUSES. ALL SYMPTOMS WILL BE LISTED. NO STANDARD NOMENCLATURE IN ITEM 18. NO SYMPTOMS WILL BE LISTED. ALL DISEASES IN PART I MUST BE CASUALLY RELATED. CORONER CANNOT CERTIFY TO A DEATH DUE TO NATURAL CAUSES.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St Joseph</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo Meth. Hospital</b>		Length of stay in 1b <b>FROM BIRTH</b>	d. STREET ADDRESS (If outside, give location) <b>3003 So. 15th St.</b>
3. NAME OF DECEASED (Type or print) First <b>VALITA</b> Middle <b>JANE</b> Last <b>Wilson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 9-1956</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>St Joseph, Mo.</b>
13. FATHER'S NAME <b>Hurthur E. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>A.E. Wilson</b> Address <b>3003 So. 15th St., St Joseph Mo.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia Neonatorum</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Stelectasis</b> DUE TO (c) <b>7620</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>12-9-56</b> to <b>12-10-56</b> and last saw her alive on <b>12-10-56</b> Death occurred at <b>4 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>D. Matherhead M.D.</b>		22b. ADDRESS <b>2603 Frederick Ave., City</b>	22c. DATE SIGNED <b>12-10-56</b>
23a. FUNERAL CREMATION, REMOVAL (Specify) <b>Funeral</b>	23b. DATE <b>12-10-1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brown Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Gallatin, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Hope Funeral Home, Gallatin, Mo.</b>		25. DATE REQD. BY LOCAL REG. <b>Dec 11, 1956</b>	26. REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b>

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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 em-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *L. C. Dickerson*

Licensed Embalmer No. *330*

P. O. Address *Gallatin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.