

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 7 - 1957

12357
STATE FILE NUMBER
Registrar's No. 112

Registration District No. 47 Primary Registration District No. 3008

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY CALLAWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY STODDARD	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FULTON		c. CITY OR TOWN LEORA	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSPITAL #1		d. STREET ADDRESS (If outside, give location) NONE	
Length of stay in lb 21 YRS.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First HAM	Middle WILSON	Last WILSON	Month 4	Day 30	Year 57

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years) 86 YRS	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	---------------------------------	---------------------------------	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	---

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
-----------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) NONE	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address STATE HOSPITAL #1, FULTON, MISSOURI
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) arteriosclerosis, general		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) .. DECUBITUS ULCERS		19. WAS AUTOPSY PERFORMED? YES

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 NOT WHILE STATE HOSPITAL #1	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	---

21. attended the deceased from **3-26-96** to **4-30-57**
Death occurred at **1:50 PM** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. D. MC CARTHY, M.D.	22b. ADDRESS STATE HOSP. #1, FULTON, MO.	22c. DATE SIGNED 4-30-57
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) 5-2-57	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY anatomical board columbian	23d. LOCATION (City, town, or county) (State)
---	-----------	--	---

24. FUNERAL DIRECTOR Robert D. Johnson ADDRESS Columbia Mo.	25. DATE RECD. BY LOCAL REG. May 2-1957	26. REGISTRAR'S SIGNATURE Maretha Lawrence
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

423

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
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

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.