

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16588

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 60

Health,
Welfare
Public
Service

300
1-56 0

Doctor, coroner, etc. must use only 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 <u>COOPER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>COOPER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BOONVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>BOONVILLE 0270</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH</u> Length of stay in 1b <u>3.H.R.</u>		d. STREET ADDRESS (If outside, give location) <u>900 WATER</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>C.</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>57</u>	
5. SEX <u>3</u> <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN-13 1879</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>LAMONTE-MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>BEN-BROWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>MAYO, WILSON 456 1/2 W. LIBERTY MO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>starvation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a. m. <u>-</u> p. m. <u>-</u>	
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.) <u>-</u>	
20f. CITY, TOWN, OR LOCATION <u>BOONVILLE</u> COUNTY <u>COOPER</u> STATE <u>MO</u>		21. I attended the deceased from <u>5-10-57</u> to <u>5-10-57</u> and last saw her alive on <u>5-10-57</u> Death occurred at <u>11:00</u> p. m. on the <u>10th</u> day of <u>MAY</u> stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Deputy or Wife) <u>Willie A. Shelb MO</u>		22b. ADDRESS <u>329 main, Boonville, Mo.</u>	
22c. DATE SIGNED <u>5-13-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>5-14-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	
23d. LOCATION (City, town, or county) <u>BOONVILLE</u> (State) <u>MO</u>		24. FUNERAL DIRECTOR <u>MAY-PARTER</u> ADDRESS <u>BOONVILLE MO 814 S. PORTER</u>	
25. DATE RECD. BY LOCAL REG. <u>5/13/57</u>		26. REGISTRAR'S SIGNATURE <u>De Hooper</u>	

(Licensed Embalmer's Statement on Reverse Side)

MAY 29 1957

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 *Edward F. Krueger*

Licensed Embalmer No. 499

P. O. Address *Columbia*

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