

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32865**

*Dr. Chapman*  
FILED OCT 10 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **272** PRIMARY REG. DIST. NO. **1908** Registrar's No. **29**

|                                                                                          |  |                                                                                                                                             |  |
|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Pemiscot</b>                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Pemiscot</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Thimonsville</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>Steele, Halland</b>                                      |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION                                                  |  | d. STREET ADDRESS (If rural, give location)                                                                                                 |  |

|                                        |             |                         |                  |                 |                  |
|----------------------------------------|-------------|-------------------------|------------------|-----------------|------------------|
| 3. NAME OF DECEASED<br>(Type or Print) |             |                         | 4. DATE OF DEATH |                 |                  |
| a. (First) <b>Betha</b>                | b. (Middle) | c. (Last) <b>Wilson</b> | (Month) <b>9</b> | (Day) <b>14</b> | (Year) <b>57</b> |

|                 |                             |                                                                      |                                 |                                 |   |                     |   |                      |   |
|-----------------|-----------------------------|----------------------------------------------------------------------|---------------------------------|---------------------------------|---|---------------------|---|----------------------|---|
| 5. SEX <b>F</b> | 6. COLOR OR RACE <b>Cal</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b> | 8. DATE OF BIRTH <b>9-14-57</b> | 9. AGE (In years last birthday) |   | 10. IF UNDER 1 YEAR |   | 11. IF UNDER 10 HRS. |   |
|                 |                             |                                                                      |                                 | 0                               | 0 | 0                   | 0 | 0                    | 2 |

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

|                                   |                                                   |                             |
|-----------------------------------|---------------------------------------------------|-----------------------------|
| 13a. FATHER'S NAME <b>Unknown</b> | 13b. MOTHER'S MAIDEN NAME <b>Betha Mae Wilson</b> | 14. NAME OF HUSBAND OR WIFE |
|-----------------------------------|---------------------------------------------------|-----------------------------|

|                                                                             |                                                                |                                                            |                            |
|-----------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|----------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 17. INFORMANT'S SIGNATURE OR NAME <b>Gulley Mae Harris</b> | ADDRESS <b>Steele Rt 2</b> |
|-----------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------|----------------------------|

|                                                                                                                                                                                                                                |                                                                                                                                                               |  |                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION                                                                                                                                         |  | INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                                | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>premature</b>                                                                                       |  |                                  |
|                                                                                                                                                                                                                                | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |                                  |
| 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 | 20. AUTOPSY? <b>no</b> |
|------------------------|----------------------------------|------------------------|

|                                          |                                                                                          |                                                 |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 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) |
|                                          |                                                                                          | <b>Steele Pemiscot Mo</b>                       |

|                                                      |                                                                                                        |                            |
|------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 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 **9-14-1957**, to **9-14-1957**, that I last saw the deceased alive on **9-14-1957**, and that death occurred at **9 A m.**, from the causes and on the date stated above.

|                                                             |                                |                                 |
|-------------------------------------------------------------|--------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <b>J. R. Chapman, M.D.</b> | 23b. ADDRESS <b>Steele, Mo</b> | 23c. DATE SIGNED <b>9-16-57</b> |
|-------------------------------------------------------------|--------------------------------|---------------------------------|

|                                           |                          |                                                     |                                                                 |
|-------------------------------------------|--------------------------|-----------------------------------------------------|-----------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE <b>9-15-57</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b> | 24d. LOCATION (City, town, or county) (State) <b>Halland Mo</b> |
|-------------------------------------------|--------------------------|-----------------------------------------------------|-----------------------------------------------------------------|

|                                         |                                          |                                              |         |
|-----------------------------------------|------------------------------------------|----------------------------------------------|---------|
| DATE REC'D BY LOCAL REG. <b>8/10/57</b> | REGISTRAR'S SIGNATURE <b>[Signature]</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>None</b> | ADDRESS |
|-----------------------------------------|------------------------------------------|----------------------------------------------|---------|

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

249  
0

10-274-57

OCT 8 - 1957

PEMISCOT COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

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 \_\_\_\_\_

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
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 this body is not embalmed, fact should be so stated above.