

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

35525

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1059

S. 300  
v. 1-57 0

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Camden</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Springfield</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Camdenton, Missouri</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Length of stay in 1b <b>10 days</b>	d. STREET ADDRESS (If outside, give location) <b>Reside on Farm</b> Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Timothy</b> Middle <b>Detweiler</b> Last <b>Willard</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1957</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1908</b>	9. AGE (In years birthday) <b>48</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Druggist</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Lynchburg, Missouri</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>Fred D. Willard</b>	13b. MOTHER'S MAIDEN NAME <b>Lula Detwiler</b>	14. NAME OF HUSBAND OR WIFE <b>Thelma Willard</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print) (If in U. S. Armed Forces, give branch, grade, and date of entry or discharge) <b>WW II 3/29/44 10/3/45</b>	16. SOCIAL SECURITY NO. <b>500-36-6924</b>	17. INFORMANT <b>James R. Willard</b>	Address <b>Camdenton, Missouri</b>
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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>Acute Blood loss -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Mo</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Squamous Cell Ca of Throat</b>	<b>8 Mo.</b>
	DUE TO (c)	
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 type="checkbox"/> NO <input checked="" 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.) <b>191X</b>
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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
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21. I attended the deceased from <b>10-20-57</b> to <b>10-31-57</b> and last saw her alive on <b>10-31-57</b> Death occurred at <b>5:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Name or title) <b>Joseph N. Hill M.D.</b>	22b. ADDRESS <b>SPRINGFIELD, MO.</b>	22c. DATE SIGNED <b>11-1-57</b>
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23a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11/2/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Rose Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Lebanon, Missouri</b>
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24. FUNERAL DIRECTOR <b>Walter P. Sledge</b>	ADDRESS <b>Camdenton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-1-57</b>	26. REGISTRAR'S SIGNATURE <b>Edith Williamson</b>
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(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

NOV 8 1957

DEC 13 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 *Walter P. Hedger* .....

Licensed Embalmer No. 4265 .....

P. O. Address Iberia, Missouri .....

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.