

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009002  
STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 72

Primary Registration District No. 1000

Registrar's No. 389

300  
-57

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1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Thompson-Brumm INSTITUTION Knepper Clinic		Length of stay in 1b 23 years		d. STREET ADDRESS RR#8 Union Road		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWIN Middle D. Last WILKERSON			4. DATE OF DEATH Month April Day 6, Year 1958				
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1873	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Co. Worker		10b. KIND OF BUSINESS OR INDUSTRY Collins Comm. Co		11. BIRTHPLACE (City and state or country) Mt. Vernon, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Wilkerson		13b. MOTHER'S MAIDEN NAME Samantha Olloman		14. NAME OF HUSBAND OR WIFE Lulu Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. R.F. Collins, St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Aortic insufficiency DUE TO (c) Luetic heart disease						INTERVAL BETWEEN ONSET AND DEATH 3 weeks unknown	
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"/> 023X	
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Jan. 23, 1956 to April 6, 1958 and last saw him alive on April 5, 1958 Death occurred at 4:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) William J. Jones MD				22b. ADDRESS 902 Edmond St.		22c. DATE SIGNED 4/7/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 8, 1958		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR E. E. ... St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. April 7, 1958		26. REGISTRAR'S SIGNATURE M. Clark Goodell			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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 *Albert R. Harrington*

Licensed Embalmer No. *3958*

P. O. Address *St. Joseph, Mo.*

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.