

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009350  
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 5-1958

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| 1. PLACE OF DEATH<br>a. COUNTY <u>Crawford</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Cuba</u>                       |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>Cuba</u> 0280<br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                               |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Family Residence</u> |  | Length of stay in 1b<br><u>4 1/2</u>  | d. STREET ADDRESS (If outside, give location) 0<br><u>901 Washington</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elizabeth</u> Middle _____ Last <u>Wilkesterr</u>               |                                  |   | 4. DATE OF DEATH<br>Month <u>3</u> Day <u>11</u> Year <u>1958</u>      |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 2 1870</u>                                 |  | 9. AGE (In years last birthday)<br><u>87</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Jeffriesburg, Mo.</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |
| 13a. FATHER'S NAME  |                                  | 13b. MOTHER'S MAIDEN NAME   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Wm. F. (Dad)</u> |   |

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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>NONE</u> | 17. INFORMANT<br><u>Mr. Amelia Skaggs</u><br>Address _____ |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>many years</u>                            |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <u>arteriosclerosis</u> |   |
|  | DUE TO (c) _____                   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>4500</u>                 |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.)<br><u>2</u> |   |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____ Year _____<br>a.m. _____ p.m. _____               |  |   |
| 20d. INJURY OCCURRED WHILE AT <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 |

21. I attended the deceased from 21 Dec 57 to 11 Mar 58 and last saw <sup>(her)</sup> alive on 27 Feb 58  
Death occurred at 10:15 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.

|   |                                     |                  |
|---|-------------------------------------|------------------|
| 22a. SIGNATURE (Degree or title)<br><u>Ronald Van Ansdell, M.D.</u> | 22b. ADDRESS<br><u>Bourbon, Mo.</u> | 22c. DATE SIGNED |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>3-13-1958</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Kinder Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Cuba, Mo.</u> |
|--|-------------------------------|--|---|

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| 24. FUNERAL DIRECTOR<br><u>R. P. [Signature]</u><br>ADDRESS<br><u>Cuba, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>3-13-1958</u> | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

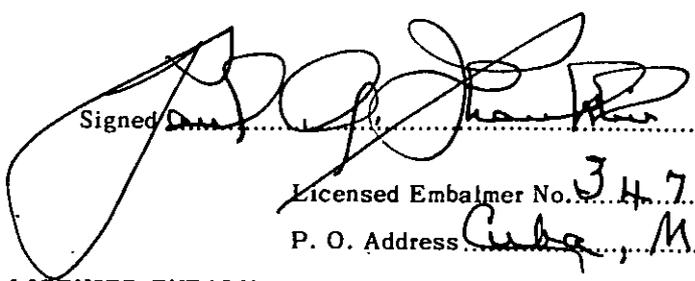
Doctor, coroner, etc. must use only black ink. All diseases in Part I must be causally related.

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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. 3472

P. O. Address Cuba, 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.