

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009739
STATE FILE NUMBER

FILED APR 7, 1958

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 93

300
-57

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WEST PLAINS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>303 W. Broadway</u>		Length of stay in lb <u>12 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>303 W BROADWAY</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Wicia</u> Middle <u>Gyson</u> Last <u>Gyson</u>			4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-24-1887</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months <u>9</u> Days <u>18</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>BAXTER Co. ARK.</u>		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <u>Freeman Buttram</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Knight</u>		14. NAME OF HUSBAND OR WIFE <u>Joe GYSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Joe Gyson West Plains 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>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension, essential</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>1. Hypertensive Cardiovascular Disease 2. Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
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.) <u></u>			
20c. TIME OF INJURY Hour <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>			
20e. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u>		STATE <u></u>	
21. I attended the deceased from <u>2-7-53</u> to <u>3-13-58</u> and last saw her alive on <u>3-12-58</u> Death occurred at <u>7:25 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert Wiles, M.D.</u> (Deceased's title)			22b. ADDRESS <u>West Plains, Mo</u>		22c. DATE SIGNED <u>3-19-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-16-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>
24. FUNERAL DIRECTOR <u>Robert Wiles</u>		ADDRESS <u></u>		25. DATE RECD. BY LOCAL REG. <u>4-4-58</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

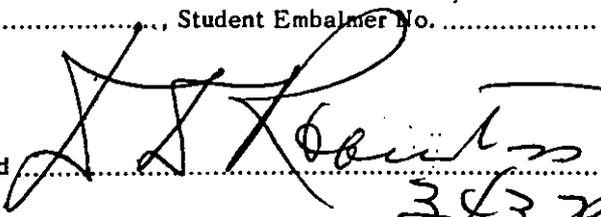
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 

Licensed Embalmer No. 3437
P. O. Address Leesville

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.