

FILED AUG 22 1958  
REG.#16769

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028391  
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 510

300  
1-57

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BUTLER</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>DUNKLIN</b>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>POPLAR BLUFF</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>KENNETT</b><br>e 352 c   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSP.</b>   |                                  | Length of stay in 1b<br><b>19 DAYS</b>  | d. STREET ADDRESS (If outside, give location)<br><b>902 WHITNEY STREET</b>                        |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>WILLIAM WALTER WILKINS</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 28, 1958</b>  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-20-91</b>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |                                  | 9b. KIND OF BUSINESS OR INDUSTRY<br><b>AGRICULTURE</b>  | 9. AGE (In years past birthday)<br><b>67</b>  |
| 10a. FATHER'S NAME<br><b>CHARLIE WILKINS</b>  |                                  | 10b. MOTHER'S MAIDEN NAME<br><b>LYDIA SMITH</b>   | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 11. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>YES WWI</b>   |                                  | 12. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   | 11. BIRTHPLACE (City and state or country)<br><b>DELL, ARKANSAS</b>                               |
| 13. FATHER'S NAME<br><b>CHARLIE WILKINS</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>LYDIA SMITH</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>NOT APPLICABLE</b>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>YES WWI</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>   | 17. INFORMANT Address<br><b>VA HOSPITAL RECORDS, POPLAR BLUFF, MO.</b>                            |
| 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) <b>HEART FAILURE PROBABLY SECONDARY TO MYOCARDIAL INFARCTION.</b>          |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 Hours.</b>  |
| DUE TO (b) <b>ACUTE PULMONARY INFARCTION, LEFT LUNG.</b>  |                                  |   | <b>48 Hours.</b>  |
| DUE TO (c) <b>GASTRO INTESTINAL BLEEDING, CAUSE UNDETERMINED.</b>   |                                  |   | <b>7 Months.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>AGRANUCYTOSSIS, ETIOLOGY UNDETERMINED, POSSIBLY ALEUKEMIA. 578X</b> |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>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, PART I or PART II of item 18)<br><b>*Sternal bone marrow block taken.</b>                        |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                                  | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. attended the deceased from <b>July 9, 1958</b> to <b>July 28, 1958</b><br>Death occurred at <b>8:20 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.         |                                  |   |   |
| 22a. SIGNATURE <i>Robert S. Cohen</i><br><b>ROBERT S. COHEN, M.D., Chief, Med. Svc.</b>   |                                  | 22b. ADDRESS<br><b>VA HOSPITAL, POPLAR BLUFF, MO.</b>   | 22c. DATE SIGNED<br><b>7/30/58</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>7-31-58</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Ridge</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Kennett, MO</b>                               |
| 24. FUNERAL DIRECTOR<br><i>McDaniel Funeral Service</i><br><b>McDaniel Funeral Service</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>8/16/58</b>  | 26. REGISTRAR'S SIGNATURE<br><i>W. H. ...</i>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AUG 2 1958

MISSOURI  
DEPT. OF HEALTH

RECEIVED

AUG 19 1958

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

DATE OF

TIME

PLACE

STATE

THIS

STATE OF MISSOURI

BY

NAME

NO.

CITY

TO

IR-06-8

STATE

NO.

DATE

TIME

PLACE

STATE

THIS

STATE OF MISSOURI

DEPT. OF HEALTH

STATE OF MISSOURI

NO.

CITY

NO.

STATE OF MISSOURI

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. 4998

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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