

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-043342  
STATE FILE NUMBER

FILED DEC 29 1958 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1366

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>BUCHANAN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ANDREW</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SAVANNAH 0020</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE Hospital #2</b>		Length of stay in lb <b>18 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>Route #1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Clyde ORVILLE WILKERSON</b>			4. DATE OF DEATH Month Day Year <b>Dec. 19, 1958</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1876</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days	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>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	11. BIRTHPLACE (City and state or country) <b>ANDREW CO., MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>J. H. WILKERSON</b>	13b. MOTHER'S MAIDEN NAME <b>LETTIE PETREE</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. LULU FAIRES</b>	Address <b>ROSENDALE, MO.</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>CORONARY THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>  <b>10 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</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) <b>4201</b>		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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from <b>Sept. 1958</b> to <b>Dec 19, 1958</b> and last saw her alive on <b>Dec 19, 1958</b> Death occurred at <b>9:55 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 <b>Mohammad Tahir</b> (Degree or title)	22b. ADDRESS <b>STATE Hosp. #2 St. Joseph</b>	22c. DATE SIGNED <b>12-19-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>12-19-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SAVANNAH CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>SAVANNAH, MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Breit Funeral Home, Savannah</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Dec. 22, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
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All diseases in Part I must be causally related.  
Dr. Mohammad Tahir  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James B. Hawkins* .....

Licensed Embalmer No. *4536* .....

P. O. Address *Savannah* .....

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.