Health, Welfare Public Service

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FILED JAN 21 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-000591
STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. Registrar's No. 7

1. PLACE OF DEATH
a. COUNTY: CLARK
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Washington — Inside Limits Yes ☐ No ☑
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clark
c. CITY OR TOWN: Wyaconda, Mo. — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: William Middle: George Last: Denning

4. DATE OF DEATH Month: Jan. Day: 13 Year: 1959

5. SEX: Male **6. COLOR OR RACE**: White **7. MARRIED** ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 28, 1900

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months 7, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Lee County Iowa
12. CITIZEN OF WHAT COUNTRY?: United States

13a. FATHER'S NAME: George A. Denning
13b. MOTHER'S MAIDEN NAME: Amanda Sherwood
14. NAME OF HUSBAND OR WIFE: Mrs. Mable Denning

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.: 481-01-5271
17. INFORMANT: Mrs Mable Denning Address: Wyaconda, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Medullary failure	minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cardiovascular collapse	minutes
DUE TO (c)	Overwhelming infection	3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Paralysis agitans

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10-4-58, to 1-4-59 and last saw her/him alive on 12-29-58
Death occurred at 3:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert L. Miller, MD
22b. ADDRESS: Kahoka, Mo
22c. DATE SIGNED: 1-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial **23b. DATE**: Jan. 15, 1959 **23c. NAME OF CEMETERY OR CREMATORY**: Gethsemane Cemetery **23d. LOCATION** (City, town, or county) (State): Ft. Madison, Iowa

24. FUNERAL DIRECTOR: Gerth & Baskett **ADDRESS**: Wyaconda, Mo.
25. DATE RECD. BY LOCAL REG.: 1/13-59
26. REGISTRAR'S SIGNATURE: J. R. Briggs

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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MAY 13 1956

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 George V. Baskett

Licensed Embalmer No. 1817

P. O. Address Wyaconda

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.