

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000809

STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 8

300  
-57

1. PLACE OF DEATH a. COUNTY <u>DUNKLIN</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>DUNKLIN</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KENNETT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MALDEN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>DUNKLIN CO. MEMORIAL HOSP</u>		Length of stay in lb <u>3 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>504 1/2 S. KIMBALL</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELLA MAY WILKINS</u>			4. DATE OF DEATH Month Day Year <u>JAN 3 1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-14-1881</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.
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 <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>STONE FORT, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>RILEY CHOAT</u>		13b. MOTHER'S MAIDEN NAME <u>MATILDA TEEL</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM WILKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Claud Wilkins, Malden, 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>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) <u>Coroic atrophy with pulmonary edema 331X</u>				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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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 <u>1-1-59</u> to <u>1-3-59</u> and last saw him alive on <u>1-1-59</u> Death occurred at <u>6:25 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Hayne Cron</u>		22b. ADDRESS <u>Malden, Mo.</u>	
22c. DATE SIGNED <u>1-6-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-5-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARIS</u>	
23d. LOCATION (City, town, or county) (State) <u>MALDEN, MO.</u>					
24. FUNERAL DIRECTOR <u>DAY + KNIGHT, F. H. MALDEN, MO.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>Jan 8-1959</u>	
26. REGISTRAR'S SIGNATURE <u>Coul Husband</u>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1956 JAN 19

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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 *J. S. Scherman* .....

Licensed Embalmer No. 4086

P. O. Address MALDEN

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.