

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004772

STATE FILE NUMBER

FILED FEB 18 1958

Registration District No. 53 Primary Registration District No. _____ Registrar's No. 48

300
-57

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Millersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Millersville</u> <u>1160</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Millersville</u>		Length of stay in lb <u>30 AM</u>	d. STREET ADDRESS (If outside, give location) <u>Main St</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>LUTHER BENNETT WILKINSON</u>			4. DATE OF DEATH Month Day Year <u>Feb. 5, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</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>July 22-1887</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days <u>7 1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stock Raising</u>	11. BIRTHPLACE (City and state or country) <u>Millersville Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William P. Wilkinon</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Walty</u>	14. NAME OF HUSBAND OR WIFE <u>Rona Steele Wilkinon</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) <u>yes (World War 1)</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Rona Steele Wilkinon</u> Address <u>Millersville 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>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Myocardial Insufficiency</u>	
	DUE TO (c) <u>Cardio-vascular-renal Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral Thrombosis</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>March 2, 1958</u> to <u>Feb. 5, 1959</u> and last saw him ^{her} alive on <u>Feb. 5, 1959</u> Death occurred at <u>9:50 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Physician or title) <u>Robert L. Stindall, M.D.</u>	22b. ADDRESS <u>Jackson, Missouri</u>	22c. DATE SIGNED <u>2/10/59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 7, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>	23d. LOCATION (City, town, or county) (State) <u>Jackson Mo</u>
24. FUNERAL DIRECTOR <u>W. Miller</u> ADDRESS <u>Jackson Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 10, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NS
FEB 19 1959

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 *Henry C. Cawthra*

Licensed Embalmer No. *4327*

P. O. Address *Jackson, Mo.*

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.