

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006694

STATE FILE NUMBER

FILED FEB 20 1959

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 16

300
-57

1. PLACE OF DEATH a. COUNTY Pulaski			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Length of stay in 1b --	d. STREET ADDRESS US Army Hospital		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Denice Middle - Last Wilson			4. DATE OF DEATH February 12 1959 Month February Day 12 Year 1959		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Feb 1959		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 6 Days 37 IF UNDER 24 HRS. Hours 6 Min 37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo	
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Horace F Wilson		
13b. MOTHER'S MAIDEN NAME Martha J Price			14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address SFC Horace Wilson Ft Leonard Wood, Mo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) Prematurity					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 11 Feb 1959 to 12 Feb 1959 and last saw her ^{her} alive on 12 Feb 1959 Death occurred at 6:10 Am on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>H. Baruch</i> H. BARUCH, Capt MC			22b. ADDRESS US Army Hospital Ft Leonard Wood, Missouri		22c. DATE SIGNED 12 Feb 59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-15-59	23c. NAME OF CEMETERY OR CREMATORY Post Cemetery		23d. LOCATION (City, town, or county) Ft Leonard Wood, Mo (State)
24. FUNERAL DIRECTOR <i>R F Hedges</i> Hedges Funeral Home Crocker, Mo			25. DATE RECD. BY LOCAL REG. 2-14-59		26. REGISTRAR'S SIGNATURE <i>Carl G. Anderson</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

Charles Moore

Licensed Embalmer No. *4896*

P. O. Address *Waymouth, Mass.*

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.