

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010305
STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 231 Primary Registration District No. _____ Registrar's No. 26

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Nodaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Elmo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Clyde
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Dr. Ford Hospital		Length of stay in 1b 2 das	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ESTELLA Middle ROSE Last WONDERLY			4. DATE OF DEATH Month 3 Day 24 Year 1959	
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8 24 1881	9. AGE (In years last birthday) 77	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 life, even if retired) housewife	10b. KIND OF BUSINESS OR OCCUPATION home own	11. BIRTHPLACE (City and state or country) Akron, Ohio	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Sapp	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Joseph A Wonderly
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no DO unknown) (If yes, give war or dates of service) DO	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Miss Margaret Wonderly, Clyde, Mo
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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) Myocardial failure due to Cerebral vascular occlusion, and ball valve thrombus of mitral valve. DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yrs. Unknown.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility. Generalized arteriosclerosis. Myocardial fibrosis. 260X		19. WAS AUTOPSY PERFORMED? 1 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	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 March 20, 1959 to March 24, 1959 and last saw him alive on March 24, 1959 Death occurred at 8:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Colonel A. ... D.O. 2</i>	22b. ADDRESS Elmo, Missouri	22c. DATE SIGNED Mar 27, 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 3/27/1959	23c. NAME OF CEMETERY OR CREMATORY St Columba Cemetery	23d. LOCATION (City, town, or county) Clyde Mo
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24. FUNERAL DIRECTOR <i>Edith ...</i>	ADDRESS <i>...</i>	25. DATE RECD. BY LOCAL REG. 3-26-59	26. REGISTRAR'S SIGNATURE <i>Bess Holt</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Occur, butler, etc. must use only standard nomenclature in item 10. No symptoms must be stated. All diseases in Part I must be causally related.

300
1-57

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 *G M Atkinson*

Licensed Embalmer No. *2279*
P. O. Address *Marionville*

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.