

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013088

STATE FILE NUMBER

APR 27 1959

Registration District No.

137

Primary Registration District No.

3023

Registrar's No.

102

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HENRY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CLINTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN CLINTON 0420
c. FULL NAME OF HOSPITAL OR INSTITUTION 201 W MILL		Length of stay in 1b 540	d. STREET ADDRESS (If outside, give location) 201 W MILL
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) MARY LIZZIE Wilkerson			4. DATE OF DEATH Month Day Year APRIL 21 1959	
--------------------------------------------------------------	--	--	-----------------------------------------------------	--

5. SEX 3 FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 25 1879	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 10 Days 26	IF UNDER 24 HRS. Hours Min.
--------------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------	---------------------------------------	--------------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
----------------------------------------------------------------------------------------------------------	-------------------------------------------	--------------------------------------------------------	-------------------------------------

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
-------------------------------	--------------------------------------	-----------------------------------------

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. no	17. INFORMANT MARTHA MASSINGALE LADUE MISSOURI	Address
--------------------------------------------------------------------------------------------------------------------	-------------------------------	---------------------------------------------------	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 12 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Myocardial Insufficiency	1 day
	DUE TO (c) Cerebral Thrombosis	1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inanition + Debilitation		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.) 332x
-----------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour Month, Day, Year 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
------------------------------------------------------	---------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------

21. I attended the deceased from 4-1-59 to 4-21-59 and last saw her alive on 4-20-59 Death occurred at 2:30 P.M. 4-21-59 on the date stated above; and to the best of my knowledge, from the causes stated.
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE Clinton L. Kasper, D.O.	(Degree or title)	22b. ADDRESS 105 E. Ohio, Clinton Mo	22c. DATE SIGNED 4/21/59
-------------------------------------------	-------------------	-----------------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-23-59	23c. NAME OF CEMETERY OR CREMATORY Antech	23d. LOCATION (City, town, or county) (State) Clinton, Henry, Mo
-------------------------------------------	----------------------	----------------------------------------------	---------------------------------------------------------------------

24. FUNERAL DIRECTOR Schaberger's	ADDRESS CLINTON, MO	25. DATE RECD. BY LOCAL REG. 4-24-59	26. REGISTRAR'S SIGNATURE Mildred Biggem
--------------------------------------	------------------------	-----------------------------------------	---------------------------------------------

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

ALL ENTRIES 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

....., Student Embalmer No. ....

working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed

*F. L. Schubert*

Licensed Embalmer No. *45-13*

P. O. Address *Clinton*

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.