

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-013124

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 39

FILED APR 21 1959

1. PLACE OF DEATH a. COUNTY <u>Nevada</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nevada</u>	
b. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>West Plains</u> <u>0460</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hosp here</u> Length of stay in lb		d. STREET ADDRESS <u>Rte 3</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Leland Earl Wonseller</u>			4. DATE OF DEATH Month Day Year <u>4-1-59</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>3-20-1889</u>		9. AGE (In years less birth day) <u>70</u> MONTHS <u>0</u> DAYS <u>11</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (City and state or country) <u>Brackendale Mo</u>	

12a. FATHER'S NAME <u>M. E. Wonseller</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Gould</u>		13a. NAME OF HUSBAND OR WIFE <u>Loekie Wonseller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>6926</u>		17. INFORMANT <u>Mrs. L. E. Wonseller, West Plains Mo</u> 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) <u>Septicemia - Staphylococci</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Staph Abscesses - Multiple</u>		
	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 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 <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 3-14-59 to 4-1-59 and last saw her alive on 4-1-59
Death occurred at 8:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr B Stoll M D</u> (Degree or title)		22b. ADDRESS <u>West Bldg No 17</u>		22c. DATE SIGNED <u>4-2-59</u>
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23a. BURIAL OR CREMATION (Specify)	23b. DATE <u>4-3-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mo Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Pomona Mo</u>
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24. FUNERAL DIRECTOR <u>Robertson West Plains Mo</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>4-17-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JAY 2 8 1959

AUG 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 *J. H. Roberts*

Licensed Embalmer No. *2430*
P. O. Address *West Hill*

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.