Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-013800
STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 73

1. PLACE OF DEATH
a. COUNTY Jasper
b. CITY OR TOWN Carthage — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION McCune-Brooks Hosp. — Length of stay in Hospital 3 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lawrence
c. CITY OR TOWN Stotts City — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) Rural — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First Eldred Middle L. Last Willbanks
4. DATE OF DEATH Month April Day 8 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Oct. 15, 1888
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Lawrence County
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Willis Willbanks
13b. MOTHER'S MAIDEN NAME Ida Strait
14. NAME OF HUSBAND OR WIFE Lola Willbanks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Lola Willbanks Address Stotts City, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial failure — Acute, 3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Coronary insufficiency — 6 months

DUE TO (c) Nephritis, chronic — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 April 5, 59, to 4-8-59 and last saw her/him alive on April 8, 59
Death occurred at 2:30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD
22b. ADDRESS Carthage, Mo
22c. DATE SIGNED 4-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4 - 12 - 59
23c. NAME OF CEMETERY OR CREMATORY Gillock Cemetery
23d. LOCATION (City, town, or county) N.E. LaRussell (State) Mo.

24. FUNERAL DIRECTOR H. D. Fossett ADDRESS Mt. Vernon, Mo.
25. DATE RECD. BY LOCAL REG. 4-10-59
26. REGISTRAR'S SIGNATURE [signature]

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

MAR 30 1961

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 me, Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed H. W. Fossett

Licensed Embalmer No. 2201

P. O. Address Mt. Vernon

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.