

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029439

FILED VS AUG 26 1959 46

Registration District No. 3026 Primary Registration District No. 361 Registrar's No. 361

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Larayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence	Length of stay in 1b 2yrs	c. CITY OR TOWN Bates City	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 4 Pines Retirement home 3713 Hardy		d. STREET ADDRESS (If outside, give location) R.F.D. 5 mi South	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Viola Middle Sebetha Last Wilkinson			4. DATE OF DEATH Month Aug Day 13 Year 1959		
5. SEX F M	6. COLOR OR RACE Wh	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-27-80	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Bates City Mo		11. BIRTHPLACE (City and state or country) USA	
13a. FATHER'S NAME William Fitzgerald		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Joseph Wilkinson	
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. None		17. INFORMANT Address Edgar Wilkinson Oak Grove Mo	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Acute Cardiac Failure			1 Day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Multiple Cerebral Emboli		2 weeks
	DUE TO (c) Arteriosclerotic Cardio-Vasc. Dis		10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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 **Aug 4, 1958** to **Aug 13, 1959** and last saw her alive on **Aug 13, 1959**
Death occurred at **10:10** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. D. Eshelman M.D.		22b. ADDRESS 9306 E New York Highway Independence Mo		22c. DATE SIGNED 8-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-15-1959	23c. NAME OF CEMETERY OR CREMATORY Shore Cemetery	23d. LOCATION (City, town, or county) Bates City	(State) Mo

24. FUNERAL DIRECTOR Webb Funeral Home Oak Grove Mo		25. DATE RECD. BY LOCAL REG. 8-15-59	26. REGISTRAR'S SIGNATURE James S. [Signature]
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~_____~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

William Freese

Licensed Embalmer No. *4733*

P. O. Address *Blue Springs*

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.