

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029866

236 ~~5819~~ FILED VS SEP 15 1959 5819 Registration District No. ~~5819~~ Primary Registration District No. 5819 Registrar's No. 47

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gravois Mills - Coage, Mo.</u>		Length of stay in 1b <u>3 years</u>		c. CITY OR TOWN <u>Gravois Mills</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gravois Mills</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Gravois Mills</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>M.</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>7</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (City and state or country) <u>Malta Bend, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>George Hamilton</u>			13b. MOTHER'S MAIDEN NAME <u>Georgia Hamilton</u>		14. NAME OF HUSBAND OR WIFE <u>John W. Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Eunice Meheud Gravois, Mills, Mo.</u>				
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>Hypertensive Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ a.m. _____ 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 <u>July 1958</u> to <u>August 1959</u> and last saw her/him alive on <u>August 1959</u> Death occurred at <u>3:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ruth Kauffman, M.D.</u>				22b. ADDRESS <u>Versailles, Mo.</u>		22c. DATE SIGNED <u>Sept. 7, 1959</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 9 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kansas City Kansas</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Scrivner Funeral Home Versailles, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-8-59</u>	26. REGISTRAR'S SIGNATURE <u>J. R. Walsh</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 27 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Scriver

Licensed Embalmer No. 4880

P. O. Address Vanessa M.

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.