

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036759

FILED VS OCT 19 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 91

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington #</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>Higginsville, Mo.</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>Memorial</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1704 Main</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>Rivers</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1959</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. <del>DATE OF BIRTH</del> <u>11-11-1876</u>		9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>27</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>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u>		11. BIRTHPLACE (City and state or country) <u>Corder, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Augustus W. Willis</u>				13b. MOTHER'S MAIDEN NAME <u>Susan B. Eppes</u>				14. NAME OF HUSBAND OR WIFE <u>never married</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>Mrs. Mabel Saylor Harlan, Iowa</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>Bronchial pneumonia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Post-op - Volvulus of sigmoid</u>										DUE TO (c) <u>1 week</u>			
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 <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>											
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>March 1950</u> to <u>Oct. 8 - 1959</u> and last saw him alive on <u>Oct 7 - 1959</u> Death occurred at <u>7:15 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>J. Kappenberg MD.</u> (Degree or title)						22b. ADDRESS <u>Higginsville, Mo</u>			22c. DATE SIGNED <u>Oct 9 - 59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-10-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City</u>		23d. LOCATION (City, town, or county) <u>Higginsville, Mo.</u>		23e. (State)					
24. FUNERAL DIRECTOR <u>F. A. Hoefer</u> <u>Higginsville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-14-59</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Galt</u>							

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Forest R. Huffer

Licensed Embalmer No. 4801

P. O. Address Higginsville

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.