

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS DEC 9 1959** 138

**59-039812**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 5523 Registrar's No. 38

MEMORIALIZED

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hickory</u>                                  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO.</u> b. COUNTY <u>Camden</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Green</u> |  | Length of stay in 1b<br><u>23 days</u>   | c. CITY OR TOWN <u>Mocks Creek</u> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION    |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>John Thomas Willis</u>                                    |                                  |   | 4. DATE OF DEATH Month Day Year<br><u>Nov. - 24 - 1959</u>         |   |   |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>white</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug-12-1876</u>                             | 9. AGE (last birthday)<br><u>82</u>                 | IF UNDER 1 YEAR<br>Months <u>3</u> Days <u>12</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farming</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Marys Co. Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S</u>           |   |
| 13a. FATHER'S NAME<br><u>Edward C. Willis</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Polly ANN. Ricker</u>   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Maudie Willis</u> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |                                  | 16. SOCIAL SECURITY NO.<br>_____  | 17. INFORMANT Address  |   |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Mo</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>senility</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)                             |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |              |
|--|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED?<br>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 s.m. Month, Day, Year p.m.  |   |  |              |
| 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 Nov-24-59 to Nov-24-59 and last saw her/him alive on Nov-24-59  
Death occurred at 12:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                  |  |
|--|----------------------------------|--|
| 22a. SIGNATURE (Degree or title)<br><u>[Signature]</u>             | 22b. ADDRESS<br><u>[Address]</u> | 22c. DATE SIGNED<br><u>Nov 25 59</u>                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>         | 23b. DATE<br><u>11-27-1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Pleasant Grove</u>            |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Allen W. Vaughan, Urbana Mo</u> |                                  | 23d. LOCATION (City, town, or county) (State)<br><u>Camden Co. MO.</u> |

|  |  |
|--|--|
| 25. DATE RECD. BY LOCAL REG.<br><u>12/1/1959</u> | 26. REGISTRAR'S SIGNATURE<br><u>Mary Johnson</u> |
|--|--|

(Licensed Embalmer's Statement on Reverse Side)

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 Allen W. Daughan

Licensed Embalmer No. 4156

P. O. Address Yorktown, Va.

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.