

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043152

FILED VS DEC 1 1959 ³⁶⁰

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 6225 Registrar's No. 190

RECORDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u> Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 M.No.Nevada 71H.W.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>Collins</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R R</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>Oliver Drury Wilson Jr.</u>			4. DATE OF DEATH Month Day Year <u>Nov. 20, 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. DATE OF BIRTH <u>7/17/40</u>	9. AGE (last birthday) <u>19</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>O.D. Wilson Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Griffine</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>491 40 6701</u>		17. INFORMANT Address <u>O.D. Wilson, Collins, 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>Skull fracture, (Severe)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>
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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		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Car-truck accident on bridge.</u>			
20c. TIME OF INJURY Hour Month, Day, Year <u>10:50 AM 11-20-59</u>					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Douglas branch</u>	20f. CITY, TOWN, OR LOCATION <u>71 highway 8Mi. N.</u>	COUNTY <u>vernon</u> STATE <u>Mo</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Richard W. Shorten</u> <u>Coroner</u>		22b. ADDRESS <u>Nevada - 100</u>		22c. DATE SIGNED <u>11/22/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/23/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newton</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Richard W. Shorten</u> <u>Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 24 - 1959</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 7 1960

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 *David C. McLeod*

Licensed Embalmer No. 4853

P. O. Address Florida, Mo.

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.