

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 6 1 1

FILED VS DEC 3 0 1959

STATE FILE NUMBER

Registration District No. 387 Primary Registration District No. 4086 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Carroll</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Tina,</b>		Length of stay in 1b <b>13 years</b>		c. CITY OR TOWN <b>Tina,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>North Part</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Asa</b> Middle <b>Clem</b> Last <b>Wilson</b>			4. DATE OF DEATH Month <b>December</b> Day <b>22,</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 26/84</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>6</b>	IF UNDER 24 HR Hours <b>6</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Drug Store Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>COMPANY</b>		11. BIRTHPLACE (City and state or country) <b>Macomb, Ill</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13a. FATHER'S NAME <b>Edward Wilson</b> 13b. MOTHER'S MAIDEN NAME <b>Minnie ?</b> 14. NAME OF HUSBAND OR WIFE <b>Frances (Edmonds) Wilson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>505-09-2554</b>		17. INFORMANT Address <b>Mrs Frances Wilson, Tina, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>heart failure</b> DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH
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 _____ Month, Day, Year _____ a.m. _____ 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 <u>1953</u> to <u>Dec 1959</u> and last saw her/him alive on <u>20 Dec 59</u> Death occurred at <u>5 A.M. 22 Dec 59</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>E. W. Allen M.D.</b> (Degree or title)			22b. ADDRESS <b>Carrollton Mo</b>			22c. DATE SIGNED <b>24 Dec 59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/24/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Avalon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Avalon, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Clifford W. Austin funeral Home Tina, Missouri.</b>			25. DATE RECD. BY LOCAL REG. <b>Dec. 24, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Rex Henderson</b>		

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 Clifford W. Austin  
Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri.

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.