

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-025982

FILED VS AUG 1 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 799 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Length of stay in 1b 50yrs	c. CITY OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2915 Lowell		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2915 Lowell
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Sarah Jane Wilson			4. DATE OF DEATH Month Day Year July 20, 1960		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1883 - 76	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR	
					Months		Days	
					Hours		Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Gentry Co, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Henry Bittick	13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE John F Wilson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT John F. Wilson	Address St. Joseph, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Lesion	INTERVAL BETWEEN ONSET AND DEATH 21 days
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
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year	
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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
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21. I attended the deceased from June 29, 1960 7/20/60 and last saw her alive on July 20, 1960
Death occurred at 7:50 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John S. Swails M.D. (Do, free or title)	22b. ADDRESS Wathana, Kansas	22c. DATE SIGNED 7-22-1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/23/60	23c. NAME OF CEMETERY OR CREMATORY Moxley Cemetery	23d. LOCATION (City, town, or county) Easton Mo (State)
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24. FUNERAL DIRECTOR John B. Pepp	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 27, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodall
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF JOHN S. SWAILS, MD

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 ~~my~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John E. Puff*

Licensed Embalmer No. **3986**

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.