

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960

=60-030375

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 126

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS, Mo</u>		Length of stay in 1b <u>1 HR</u>	c. CITY OR TOWN <u>WEST PLAINS,</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 Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1203 WASHINGTON</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KAREN</u> Middle <u>WILKERSON</u> Last <u>WILKERSON</u>			4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>6-26-60</u>	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)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>WEST PLAINS Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>	
13a. FATHER'S NAME <u>EUGENE WILKERSON</u>			13b. MOTHER'S MAIDEN NAME <u>ROSELEE COBLE</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROSELEE COBLE WILKERSON</u> Address		

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>PREMATURITY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u>		
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) <u>Birth weight 7 1/2 lbs</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____					
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>6-26-60</u> to <u>6-26-60</u> and last saw her <u>alive</u> on <u>6-26-60</u> Death occurred at <u>7 3:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Jack M. Wilson, M.D.</u>			22b. ADDRESS <u>West Plains, Mo.</u>		22c. DATE SIGNED <u>8-26-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>6-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dripping Springs</u>		23d. LOCATION (City, town or county) (State) <u>WEST PLAINS, Mo.</u>	
24. FUNERAL DIRECTOR <u>J. J. PATTERSONS</u> ADDRESS <u>West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.