

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 13 1960

-60-033748

DED

Registration District No. 11 Primary Registration District No. 5050 Registrar's No. 87

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BARRY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY BARRY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MINERAL SPRINGS TWP.		Length of stay in 1b 53 yrs		c. CITY OR TOWN CASSVILLE		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 8 Mi. S-E of Cassville				d. STREET ADDRESS (If outside, give location) 8 Mi. S-E of Cassville		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FOREST Middle WILSON Last WILSON				4. DATE OF DEATH Month OCT. Day 2 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/31/90	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING			10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (City and state or country) SPRINGDALE, ARK.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME J. M. A. WILSON			13b. MOTHER'S MAIDEN NAME MARY MINOR		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) YES WW I			16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address HARY WILSON, CASSVILLE, MISSOURI			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic bronchitis Tuberculosis							INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
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>May</u> to <u>Aug</u> and last saw ^{her} him alive on <u>Aug 28-1960</u> Death occurred at <u>12-22</u> <u>2</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Glenn H. Salzer M.D.				22b. ADDRESS Cassville Mo		22c. DATE SIGNED Oct 3-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/5/60	23c. NAME OF CEMETERY OR CREMATORY Mano Cemetery		23d. LOCATION (City, town, or county) (State) Barry Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS Doyle E. Williamson, Cassville, Mo.				25. DATE RECD. BY LOCAL REG. Oct 4-1960		26. REGISTRAR'S SIGNATURE Grace Williams	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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

James Kenneth Duncan
Signed _____

licensed Embalmer No. 476
P. O. Address Wheaton

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.