

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034023

FILED VS OCT 3 1960 43

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 531

ENDED

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fisk	Length of stay in 1b 23Yrs	c. CITY OR TOWN Fisk	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At home in Fisk		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Wilson	4. DATE OF DEATH Month 9 Day 2 Year 60
---	--

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 10-15-1892	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
----------------------	-------------------------------	---	------------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and state or country) Hopkinsville, KY,	12. CITIZEN OF WHAT COUNTRY USA
---	--	--	---

13a. FATHER'S NAME Joseph M. Miller	13b. MOTHER'S MAIDEN NAME Millisie Jane Miller	14. NAME OF HUSBAND OR WIFE John H. Wilson
---	--	--

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 H. Wilson. Fisk, Mo.
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation		INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cor Pulmonale	?
	DUE TO (c) Pulmonary Tuberculosis.	?

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 _____ Month, Day, Year _____ a.m. _____ p.m. _____

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 **1959** to **2 Sept 60** and last saw her alive on **1 Sept 60**
Death occurred at **11:30 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title) MD 221 Oak Poplar Hopkville Ky	22b. ADDRESS	22c. DATE SIGNED
---	--------------	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-5-60	23c. NAME OF CEMETERY OR CREMATORY Ash Hill	23d. LOCATION (City, town, or county) Butler, Co Mo.
--	----------------------------	---	--

24. FUNERAL DIRECTOR J.C. White ADDRESS Fisk, Mo.	25. DATE RECD. BY LOCAL REG. 9/24/60	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Name of Deceased _____
 Address _____
 City _____
 State _____
 Date of Death _____
 Cause of Death _____
 Place of Death _____
 Name of Embalmer _____
 Address _____
 City _____
 State _____
 Date of Embalming _____
 Place of Embalming _____

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 Raymond L. Duffer
 4798
 Licensed Embalmer No. _____
 P. O. Address Concord, N.C.

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.