

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034553

FILED VS OCT 3 1960

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 237

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		Length of stay in 1b <u>5 days</u>		c. CITY OR TOWN <u>Clinton</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton Gen. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R7D#6 - Pebo twp</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA NELLIE WILSON</u>				4. DATE OF DEATH Month Day Year <u>Sept 28 1960</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days <u>5 27</u>	IF UNDER 24 HR Hours Min. <u>— —</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Henry Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Wm Kampse</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Kearn</u>		14. NAME OF HUSBAND OR WIFE <u>Alfred Wilson</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Alfred Wilson Clinton Mo #66</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>Cerebral Vascular accident</u> DUE TO (b) <u>Cerebral artery thrombosis</u> DUE TO (c) <u>Nephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause test.							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephritis</u>					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						
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 a.m. 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>1952</u> to <u>Sept 1960</u> and last saw her alive on <u>28-Sept-60</u> Death occurred at <u>5:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							22a. SIGNATURE (Degree or title) <u>James Smith MD</u>	22b. ADDRESS <u>Clinton Mo</u>		22c. DATE SIGNED <u>9-30-60</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calhoun</u>		23d. LOCATION (City, town, or county) <u>Calhoun Mo.</u>		23e. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>					
24. FUNERAL DIRECTOR <u>F.L. SCHABERG</u>			ADDRESS <u>CLINTON, MO</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 30 1960</u>		26. REGISTRAR'S SIGNATURE				

(Licensed Embalmer's Statement on Reverse Side)

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F L Schabug

Licensed Embalmer No. 4513

P. O. Address Clinton

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