

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 20 1960

53

3010

491-60-045370

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> COUNTY <u>Cape Girardeau</u>					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>5 mo.</u>		c. CITY OR TOWN <u>Neelys Landing Mo</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>Wilson Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>near Neelys Landing</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>JANE</u> Last <u>WILLS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15, 1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housekeeping</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>near Millerwood Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William Yates</u>			13b. MOTHER'S MAIDEN NAME <u>Mollie Yates</u>			14. NAME OF HUSBAND OR WIFE <u>Robert M. Wills</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>none</u>		17. INFORMANT <u>Mrs Lloyd Casteel, Jackson Mo</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>							<u>6 mo.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Artery Disease</u>							<u>5 yrs.</u>		
DUE TO (c) <u>Generalized Arteriosclerosis</u>							<u>10 yrs.</u>		
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 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 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>April 1950</u> to <u>12-6-60</u> and last saw her <u>alive</u> on <u>12-4-60</u> Death occurred at <u>2:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>E.F. McDonald, MD</u> (Degree or title)				22b. ADDRESS <u>Jackson, Mo.</u>			22c. DATE SIGNED <u>12-10-60</u>		
23a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	23b. DATE <u>Dec 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Fruitland Mo</u>					
24. FUNERAL DIRECTOR <u>W. Miller Jackson Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>12-14-60</u>		26. REGISTRAR'S SIGNATURE <u>Dorene Karter</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 *G. C. Mudgett*

Licensed Embalmer No. 4327

P. O. Address *Jackson*

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.