

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020663

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 5200 Registrar's No. 61

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH 11-11-1961

a. COUNTY Carroll

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Wakenda Length of stay in lb Life

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION His Home Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) Wakenda Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri COUNTY Carroll

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year

William Norman Wilson 6-30-61

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9-28-82 9. AGE (last birthday) 78

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min. 9 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (City and state or country) Wakenda Missouri. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Peter Wilson 13b. MOTHER'S MAIDEN NAME Clara Warren 14. NAME OF HUSBAND OR WIFE Anna Bell Sims.

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. No 17. INFORMANT Address Mrs William Wilson (Wakenda 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) Acute Uremia INTERVAL BETWEEN ONSET AND DEATH 4 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Pyelonephritis ?

DUE TO (c) Carcinoma of Prostate ?

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 5-25-56 to 6-23-61 and last saw her alive on 6-23-61 Death occurred at 10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William A. Ernest MD 22b. ADDRESS Carrollton Mo 22c. DATE SIGNED 7-3-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 7-3-61 23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetry 23d. LOCATION (City, town, or county) (State) Carrollton Mo.

24. FUNERAL DIRECTOR ADDRESS Marshall F. Home (Carrollton Mo) 25. DATE RECD. BY LOCAL REG. 7-3-61 26. REGISTRAR'S SIGNATURE Thos. Herbert Calvert

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton, M

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.