

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031725

STATE FILE NUMBER

AMENDED

Registration District No. 1 Primary Registration District No. Registrar's No. 263

FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Novinger</u>		c. CITY OR TOWN <u>Novinger</u>	
Length of stay in 1b <u>40 yrs.</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>R.F.D. 1</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D. 1</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Beverly</u> Middle <u>E.</u> Last <u>Wimber</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>Male</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>9-19-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Adair co., MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Wimber</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Bogarth</u>	
14. NAME OF HUSBAND OR WIFE <u>Mary C. Wimber</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>		17. INFORMANT <u>Mary Wimber</u> Address <u>Novinger, Mo.</u>	

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>Chronic Enlargement of Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
DUE TO (b) <u>Bronchial Asthma</u>		
DUE TO (c) <u> </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 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 <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u>	

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 <u>Novinger, Mo.</u>	COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>Jan 1960</u> to <u>Sept 12-1961</u> and last saw him alive on <u>Sept 11-61</u> . Death occurred at <u>7:43 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>H. Garrison M.D.</u> (Degree or title)	22b. ADDRESS <u>Novinger, Mo.</u>	22c. DATE SIGNED <u>Sept 13-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-15-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park Cem.</u>
23d. LOCATION (City, town, or county) <u>Kirkville, Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Dee Riley Funeral Home, Inc.</u> ADDRESS <u>Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 14, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Pettif</u>
<u>W.R. Jackson Pres.</u> (Licensed Embalmer's Statement on Reverse Side)		

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

H. T. GARRISON, M.D.

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 Kenneth E. Hays

Licensed Embalmer No. 4890

P. O. Address Kirkville, Mo.

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.

13-24