

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**=61-040331**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 277

AMENDED **FILED NOV 21 1961**

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fulton</u>		Length of stay in 1b <u>6 1/2 mo</u>	c. CITY OR TOWN <u>New Bloomfield</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>312 E. 2<sup>nd</sup> Street</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 mi. N.E. New Bloomfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Willis</u> Last <u>Wade</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>July 21 - 82</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> 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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Haile England</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Abraham Willis</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND <u>Herbert Brown Wade</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 Address <u>Willis Wade New Bloomfield MO</u>		

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 <u>9 months</u>
IMMEDIATE CAUSE (a) <u>Chr. myocarditis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerosis with hypertension</u> <u>years</u>	
DUE TO (c) _____		
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 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 2/27/61 to 11/17/61 and last saw her alive on 11/14/61  
Death occurred at 1/15 A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Henry Durr M.D.</u> (Degree or title)	22b. ADDRESS <u>Fulton, Mo.</u>	22c. DATE SIGNED <u>11/7/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov 9 - 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>R.F.D. Fulton MO</u>
24. FUNERAL DIRECTOR <u>Claypool Service</u>	ADDRESS <u>New Bloomfield MO</u>	25. DATE RECD. BY LOCAL REG. <u>Nov-17-1961</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address W Bloomfield

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.