

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045440  
STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5653 Registrar's No. 121

AMENDED

FILED DEC 22 1961

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>20 DAYS</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>700 E. Garfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harnett</u> Middle <u>Wilkinson</u> Last <u>Wilkinson</u>			4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>61</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-09</u>	9. AGE (last birthday) <u>52</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mattress factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mattress factory</u>		11. BIRTHPLACE (City and state or country) <u>Niangua, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Wilkinson</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Terry</u>		14. NAME OF HUSBAND OR WIFE	

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.	17. INFORMANT <u>Hospital Record, Mo. SS, Mt. Vernon, Mo.</u> Address
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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>20 days</u>
IMMEDIATE CAUSE (a) <u>Myocardial ischemia; probable coronary insufficiency &amp; severe malnutrition</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>malnutrition</u>	
	DUE TO (c) <u>arteriosclerotic heart disease &amp; angina</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Tuberculosis, far advanced, active</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown	
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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>7:05 P</u> a.m. p.m.	Month, Day, Year <u>12-20-61</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 12-20-61 to 12-10-61 and last saw her/him alive on 12-10-61, 6:30 AM.  
Death occurred at 7:05 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>H. Vernon Langstaff M.D.</u>		22b. ADDRESS <u>Mo. State Sanatorium</u>		22c. DATE SIGNED <u>12-10-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NIANGUA</u>	23d. LOCATION (City, town, or county) (State) <u>NIANGUA, MO</u>	
24. FUNERAL DIRECTOR <u>BARBER-EDWARDS, MARSHFIELD,</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-22-1961</u>	26. REGISTRAR'S SIGNATURE <u>Hurstard W. M. D.</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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 3848

P. O. Address Watauga

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.

STATE BOARD OF HEALTH, WASHINGTON, D. C.