SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-047733
STATE FILE NUMBER

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 20

FILED JAN 16 1962

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence
Length of stay in 1b 1 Day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep Hosp
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY Clay
c. CITY OR TOWN Liberty
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 308 S Leonard (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: STELLA Middle: M Last: WILSON
4. DATE OF DEATH Month: Dec. Day: 22 Year: 61
5. SEX F
6. COLOR OR RACE W
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Aug 17-1885
9. AGE (last birthday) 76
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner. Farm Co.
10b. KIND OF BUSINESS OR INDUSTRY ✓
11. BIRTHPLACE (City and state or country) Ellis Co. Kans.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John H. Wilson
13b. MOTHER'S MAIDEN NAME Ella S. Yates
14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT Harvey Wilson – Liberty Mo. Address

MEDICAL CERTIFICATION

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)	Peritonitis	6 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Thrombosis of mesenteric artery	12 hr
DUE TO (c)	Arteriosclerosis, Generalized	30 yrs.

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 12-21-61 to 12-22-61 and last saw her/him alive on 12-22-61
Death occurred at 4:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William L Cox MD (Degree or title)
22b. ADDRESS Liberty, Mo.
22c. DATE SIGNED 12-23-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 12-23-61
23c. NAME OF CEMETERY OR CREMATORY Fairview
23d. LOCATION (City, town, or county) (State) Liberty Mo

24. FUNERAL DIRECTOR Church-Archer Co. ADDRESS Liberty Mo
25. DATE RECD. BY LOCAL REG. 12-22-61
26. REGISTRAR'S SIGNATURE Alva L. Craig

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

INSTEAD OF

DATE AMENDED

VS JAN 17 1962

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 Gordon Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, 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.