

Registration District No. **187**

Primary Registration District No. **3090**

1. PLACE OF DEATH:
 (a) County **Livingston**
 (b) City or town **Chillicothe**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1112 Maple St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **XX**
(Specify whether
 In this community **3 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Livingston** **SP**
 (c) City or town **Chillicothe**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1112 Maple St.**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **XX**

3. (a) PRINT FULL NAME **Ben Willsey**
 3. (b) If veteran, name war **XX** 3. (c) Social Security No. **XX**
 4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Zoe Willsey** 6. (c) Age of husband or wife if alive **76** years
 7. Birth date of deceased **October 25, 1868**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **19**
 year **1947** hour **5** minute **15** P.M.
 21. I hereby certify that I attended the deceased from **May 15** 19**47** to **July 19** 19**47**
 that I last saw him alive on **July 19** 19**47**
 and that death occurred on the date and hour stated above.
 Immediate cause of death **Cerebral thrombosis**
 Duration **4 weeks**

8. AGE:	Years	Months	Days	If less than one day
	78	8	24	X hr. X min.

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death)
 Major findings: **94A**
 Of operations _____
 Of autopsy _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

9. Birthplace **Cobleskille** **New York**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Mail carrier, retired**
 11. Industry or business _____
MOTHER FATHER
 12. Name **Perry Willsey**
 13. Birthplace **Unknown** **New York**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown** **Unknown**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Mrs. Zoe Willsey**
 (b) Address **Chillicothe, Mo.**
 17. (a) **Burial** (b) Date thereof **7/22/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Trenton, Missouri**
 18. (a) Signature of funeral director _____
 (b) Address **Chillicothe, Missouri**
 19. (a) **July-21-47** (b) **Frances B. Neill**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) (e) Means of injury **O**
 23. Signature **[Signature]** (M. D. or other) _____
 Address **Chillicothe, Mo.** Date signed **7-21-47**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DISTRICT HEALTH OFFICE
Cameron, Mo.

AUG 13 1947

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Wayne Collins*

Licensed Embalmer No. *1164*

P. O. Address. *Chillicothe 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 this body is not embalmed, fact should be so stated above.