

FILED JAN 27 1949

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH
State File No. 70

BIRTH NO. _____		REG. DIST. NO. <u>10</u>		PRIMARY REG. DIST. NO. <u>3037</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>Audrain</u>		b. STATE <u>Mo.</u>		b. COUNTY <u>Audrain</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>4</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural SALT RIVER</u>		c. LENGTH OF STAY (in this place) <u>25 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Mexico SALT RIVER Twp</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Audrain Co. Infirmiry 5</u>				d. STREET ADDRESS <u>R. #5 Mexico Mo</u>			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)				
a. (First) <u>Joseph Wiley</u>		b. (Middle) <u>Hinton</u>		c. (Last)		Jan. 16, 1949	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1847</u>	9. AGE (In years last birthday) <u>101</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County patient</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dont Know</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>County Court Records Mexico, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cavernous-Sinus Thrombosis</u>					<u>4 days</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Laceration of forehead with cellulitis</u> of unknown etiology DUE TO (c) <u>Gen</u>					<u>3 days</u>
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>					
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT X SUICIDE HOMICIDE No (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>County Infirmiry</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mexico Audrain Missouri</u>			
21d. TIME OF INJURY <u>1-11-49 A.M.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>He fell out of bed</u>			
22. I hereby certify that I attended the deceased from <u>1-12</u> , 1949, to <u>1-16</u> , 1949, that I last saw the deceased alive on <u>1-14</u> , 1949, and that death occurred at <u>11:00A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ernest J. Santt, Jr. M.D.</u>				23b. ADDRESS <u>105a West Monroe Mexico, Missouri</u>		23c. DATE SIGNED <u>1-17-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/17/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>		24d. LOCATION (City, town, or county) (State) <u>Centralia, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Jan 17-49</u>		REGISTRAR'S SIGNATURE <u>Bonche Neely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. Cassidy</u>		ADDRESS <u>Mexico, Mo.</u>	

STANDARD FORM NO. 1

**RECEIVED**

District Health Officer No. 10

District File Number 149-159

Date Filed JAN-25 1949

**STATEMENT BY LICENSED EMBALMER**

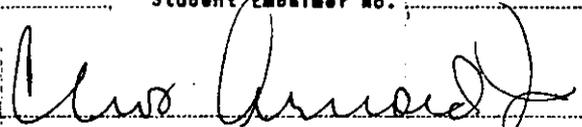
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. 3569

P. O. Address Michigan, MI

**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.