

FILED OCT 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34279

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BIRTH NO. _____ REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 5637 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lafayette	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Clay Twms.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Odessa	
c. LENGTH OF STAY (In this place) 8 weeks		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Goodloe Nurseing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) Lewis Wilkening			4. DATE OF DEATH (Month) (Day) (Year) Oct. 9, 1949
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH aug, 19, 1859
9. AGE (In years last birthday) 90		# UNDER 1 YEAR Months	# UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Christian Wilkening	
13b. MOTHER'S MAIDEN NAME Mary Kleningberg		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Earl Wilkening		ADDRESS Odessa, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart disease probably Coronary Occlusion. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Based at autopsy Faint dead in bed after 6 AM DUE TO (c) 9-10-49. Dead 6-8 hrs before he was found Had been treated for heart condition	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION No operation	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) M		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from called as coroner, 19 10-10-49, that I last saw the deceased alive on _____, 19 _____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. Martin M.D. Coroner		23b. ADDRESS Odessa Mo	
23c. DATE SIGNED 10-10-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 11, 1949	
24c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery		24d. LOCATION (City, town, or county) (State) Odessa, Mo.	
DATE REC'D BY LOCAL REG. Oct. 11-1949		REGISTRAR'S SIGNATURE L. H. Drummond	
25. FUNERAL DIRECTOR'S SIGNATURE Husman Sparks		ADDRESS Odessa, Mo.	

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

RECEIVED

OCT 14

District Health Officer No. 8,

District File Number _____

Date Filed _____

10-15-49

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 *William T. Sparks*

Licensed Embalmer No. *#4431*

P. O. Address *Odessa, 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.