

FILED JUN 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17473

0742

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

BIRTH NO. _____		REG. DIST. NO. 251		PRIMARY REG. DIST. NO. 3048		Registrar's No. 129	
1. PLACE OF DEATH a. COUNTY Stoddard NODAWAY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Stoddard			
b. CITY OR TOWN Stoddard		c. LENGTH OF STAY (In this place) 43 yrs		c. CITY (If outside corporate limits, write RURAL and give township) STANBERRY, MO		d. STREET ADDRESS (If rural, give location) N. WILLOW	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED a. (First) JANE b. (Middle) ISABELLE c. (Last) WILKESFORD			4. DATE OF DEATH (Month) (Day) (Year) May 24-1951				
5. SEX F		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 5-1877	
9. AGE (In years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Stoddard Co. Mo	
12. CITIZENRY OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Rufus B. James		13b. MOTHER'S MAIDEN NAME Nancy Gearhart		14. NAME OF HUSBAND OR WIFE Sidney Wilkiford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Miss Myra Jones ADDRESS Stoddard 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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Dilatation					INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis					
		DUE TO (c) Chronic Nephritis					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Nephritis					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		4222	
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 4-3 , 19 50 , to May 24 , 19 51 , that I last saw the deceased alive on 5-24 , 19 51 , and that death occurred at 1:30 p.m., from the causes and on the date stated above.							
23a. SIGNATURE W.R. Jackson, M.D. (Degree or title)			23b. ADDRESS Marquardt Mo.		23c. DATE SIGNED 5/26/51		
24a. BURIAL CREMATION, REMOVAL, REPOSITING Burial		24b. DATE 5/27/51	24c. NAME OF CEMETERY OR CREMATORY High Ridge		24d. LOCATION (City, town, or county) (State) Stoddard, Mo		
DATE REC'D BY LOCAL REG. 6-2-51		REGISTRAR'S SIGNATURE Bess Holt		25. FUNERAL DIRECTOR'S SIGNATURE Leroy H. Phillips ADDRESS Stoddard Mo			

JUN 15 1951



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

~~working under my personal supervision.~~

Student Embalmer No.

Signed

Leroy R. Phillips

Signed.....
Student Embalmer

Licensed Embalmer No. 1898

P. O. Address Stouffville, N.C.

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.