

APR 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13714

BIRTH NO. _____		REG. DIST. NO. <u>254</u>		PRIMARY REG. DIST. NO. <u>5860</u>		Registrar's No. <u>13</u>							
1. PLACE OF DEATH a. COUNTY <u>Oregon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Oregon</u>									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koshkonong rural Big Apple</u>			c. LENGTH OF STAY (in this place) <u>35 yr</u>			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Koshkonong rural Big Apple</u>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Koshkonong rural</u>				d. STREET ADDRESS (If rural, give location) <u>Koshkonong rural</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>SARAH</u>			b. (Middle) <u>REBECCA</u>		c. (Last) <u>STILWELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17, 1952</u>						
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Sept. 23, 1858</u>		9. AGE (In years last birthday) <u>93</u>		IF UNDER 1 YEAR Months Days		IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and State or Foreign Country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13a. FATHER'S NAME <u>Aaron Walker</u>				13b. MOTHER'S MAIDEN NAME <u>Unknown</u>				14. NAME OF HUSBAND OR WIFE <u>William Stilwell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>John Stilwell</u> ADDRESS <u>Logan Iowa</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary failure</u> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>Hypertensive CV disease</u> DUE TO (c) <u>Coronary degeneration</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>								INTERVAL BETWEEN ONSET AND DEATH <u>year</u>			
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) <u>443 X</u>								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>4-16</u> , 19 <u>52</u> , and that death occurred at _____ m., from the causes and on the date stated above.													
23a. SIGNATURE <u>A. Walker M.D.</u> (Degree or title)						23b. ADDRESS <u>Mammoth Spring Ark.</u>			23c. DATE SIGNED <u>4-23-52</u>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>4/21/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Koshkonong Cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>Koshkonong, Oregon, Mo.</u>						
DATE REC'D BY LOCAL REG. <u>Apr. 24, 1952</u>		REGISTRAR'S SIGNATURE <u>Anthony Wolf</u> 46879			25. FUNERAL DIRECTOR'S SIGNATURE <u>Illand Carter</u> ADDRESS <u>Thelma</u>								

(Licensed Embalmer's Statement on Reverse Side)

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

0750
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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 *Leland Carter*
Licensed Embalmer No. 4516

P. O. Address *Thayer Ave*

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.