

FILED AUG 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25680**

BIRTH NO. _____ REG. DIST. NO. **82** PRIMARY REG. DIST. NO. **3017** Registrar's No. **83**

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). -a.-STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give township) Boonville	c. LENGTH OF STAY (In this place) 1 day	c. CITY OR TOWN	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital		e. STREET ADDRESS (If rural, give location) RFD Prairie Home 0270	

3. NAME OF DECEASED (Type or Print)	a. (First) WILLIE	b. (Middle) (none)	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) August 17, 1955
-------------------------------------	--------------------------	---------------------------	-------------------------	---

5. SEX male	6. COLOR OR RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) approx 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (City and State or Foreign Country) Cooper County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE -----
--------------------------------------	---	--------------------------------------

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 Kathryn Boles	ADDRESS RFD Prairie Home, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH (9)
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4500		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)
--	--	---

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 **May 1953**, to **Aug 17, 1955**, that I last saw the deceased alive on **Aug 16, 1955**, and that death occurred at **7:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE M. L. DeGraaf M.D.	(Degree or title) (City, State)	23b. ADDRESS Boonville Mo	23c. DATE SIGNED 8/17/55
---	---------------------------------	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 8/19/55	24c. NAME OF CEMETERY OR CREMATORY New Lebanon	24d. LOCATION (City, town, or county) (State) Cooper County, Missouri
--	-----------------------------	--	---

DATE REC'D BY LOCAL REG. 8/17/55	REGISTRAR'S SIGNATURE D. Hooper 3818	25. FUNERAL DIRECTOR'S SIGNATURE B.W. Shacker	ADDRESS Boonville Mo
--	--	---	--------------------------------

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

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.....
Signature of Student Embalmer

Signed *Berry W. Hacker*.....

Licensed Embalmer No. *394*.....

P. O. Address *Bronx*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.