

STANDARD CERTIFICATE OF DEATH

STATE OF MISSOURI

20253 533

FILED JUN 18 1956

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 533

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Willard	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If outside, give location) RFD#1	
3. NAME OF DECEASED (Type or print) First VIOLA Middle Last WILSON		4. DATE OF DEATH Month June Day 11 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 May 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 53
11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul H. Hoffman		14. MOTHER'S MAIDEN NAME Unknown	
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. UNK NOWN	
17. INFORMANT Paul H. Hoffman (Father)		Address Willard, Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral + pulmonary emboli from DUPLICATE (b) Rh. ht. dis in actis + mitral stenosis DUPLICATE (c) + phlebotrombosis of leg vein Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 week years uncertain
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 410X			
20c. TIME OF INJURY Hour a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Springfield		COUNTY Greene	
20g. STATE Missouri			
21. I attended the deceased from 6-8-56 to 6-11-56 and last saw her alive on 6-11-56 Death occurred at 12:50 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Howard Marshall, M.D.		22b. ADDRESS 609 Cherry Springfield, Missouri	
22c. DATE SIGNED 6-14-56			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-13-56	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Greene County, Missouri	
24. FUNERAL DIRECTOR J. W. Klingner & Co.		25. DATE RECD. BY LOCAL REG. 6-14-56	
ADDRESS Springfield, Mo.		26. REGISTRAR'S SIGNATURE James Williamson	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Max Fl...*
.....
Licensed Embalmer No.....

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.