

HEALTH DEPARTMENT OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26393

STATE FILE NUMBER

FILED SEP 4 1956

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 252

1. PLACE OF DEATH a. COUNTY <u>COLE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>OSAGE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>BONNOTS MILL</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARVS HOSP</u> Length of stay in lb <u>10 days</u>		d. STREET ADDRESS (If outside, give location) <u>STAR RT</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>SAMUEL</u> Last <u>WILSON</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>28</u> Year <u>1956</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 29, 1875</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR If on the <u>11</u> Day <u>29</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>OSAGE COUNTY MO</u>
13. FATHER'S NAME <u>JAMES F. WILSON</u>		14. MOTHER'S MAIDEN NAME <u>MARIA MANTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>J.D. WILSON</u> Address <u>LINN, MO.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bilateral Hydronephrosis</u> DUE TO (c) <u>60ix</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Arterio-sclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> Month; Day, Year	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE
21. I attended the deceased from <u>July 25, 1956</u> to <u>Aug 28, 1956</u> and last saw her alive on <u>Aug 28, 1956</u> Death occurred at <u>9:35 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Herbert P. Morton M.D.</u>		22b. ADDRESS <u>Jefferson City, Mo.</u>	22c. DATE SIGNED <u>Aug 29, 1956</u>
23a. BURIAL, CREMATION, REBURY (Specify) <u>BURIAL</u>	23b. DATE <u>8/30/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINN MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>LINN, MO.</u>
24. FUNERAL DIRECTOR <u>Clyde Norton</u> ADDRESS <u>Linn, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>29 Aug 1956</u>	26. REGISTRAR'S SIGNATURE <u>R. P. Derris MD JR</u>

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare Public Service  
300 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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.....  
Signature of Student Embalmer

Signed *Vernon M. Boston*.....

Licensed Embalmer No. *412*

P. O. Address *Leominster*

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.