

FILED DEC 14 1956

STANDARD CERTIFICATE OF DEATH

State File No. **38735**

BIRTH NO. _____		REG. DIST. NO. 200		PRIMARY REG. DIST. NO. 5725		Registrar's No. 231	
1. PLACE OF DEATH a. COUNTY Macon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Iowa b. COUNTY Polk			
b. CITY (If outside corporate limits, write RURAL and give township) Rural-Hudson System		c. LENGTH OF STAY (in this place) 8 1/2		c. CITY (If outside corporate limits, write RURAL and give township): Des Moines		d. STREET ADDRESS (If rural, give location) 8140	
d. FULL NAME OF HOSPITAL OR INSTITUTION Stillbrock Sanatorium				3. NAME OF DECEASED a. (First) Susie b. (Middle) _____ c. (Last) Wiley			
4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1956		5. SEX Female		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH April 21, 1868		9. AGE (In years, Month, Day, Hours, Min.) 88		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Keytesville Mo.		12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME Thomas Witt		13b. MOTHER'S MAIDEN NAME Emily Latham	
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 Robert Jackson Des Moines Ia	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Bronchopneumonia ANTECEDENT CAUSES DUE TO Thrombotic encephalomalacia 9 yrs DUE TO Advanced Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
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) 332 X			
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 Jan 8, 1949 , to Nov. 18, 1956 that I last saw the deceased alive on Nov. 17, 1956 and that death occurred at 6:50 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE H. P. Hoyle (Name or title)				23b. ADDRESS R.O. 2 Macon Mo.		23c. DATE SIGNED Nov. 18-56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 11-23-1956		24c. NAME OF CEMETERY OR CREMATORY Glendale		24d. LOCATION (City, town, or county) (State) Des Moines Iowa	
DATE REC'D BY LOCAL REG. 12/3/56		REGISTRAR'S SIGNATURE Cuth McNeely		25. FUNERAL DIRECTOR'S SIGNATURE R. R. Rostenham Macon Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed 12/16/58

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 *R. Lester Bean*

Licensed Embalmer No. *472*

P. O. Address *Winston, Mo.*

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.