

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44514

FILED JAN 7 1957

STATE FILE NUMBER

Registration District No. 361 Primary Registration District No. 4515 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1050</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Leola</u> Middle <u>Marie</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1956</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</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>10-9-1913</u>		9. AGE (In years last birthday) <u>43</u> IF UNDER 1 YEAR: Months <u>43</u> Days <u>2</u> Hours <u>22</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Hovinger - Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Hazael Green</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Compton</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 <u>Lillie Green</u>		Address <u>Milan 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>Gun shot wound - Back -</u> <u>between shoulder -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>between shoulder -</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Family trouble</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>shot gun - Blast - by husband.</u>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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.) <u>427 S. E. 1st street</u>		20f. CITY, TOWN, OR LOCATION <u>Milan - Sullivan - Mo.</u>		COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>3:15</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>E. M. Ingram D. O. Coroner</u>				22b. ADDRESS <u>Milan - Mo.</u>		22c. DATE SIGNED <u>1-3-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1-2-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Ceme.</u>		23d. LOCATION (City, town, or county) (State) <u>Milan - Mo</u>			
24. FUNERAL DIRECTOR <u>Schoene</u> <u>Dorothy Schoene</u>			ADDRESS <u>Milan Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard non-removable forms. Diseases in Part I must be causally related. Caroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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..... *Dwight Schoene*

Licensed Embalmer No. *264*

P. O. Address *Milwaukee*

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.