

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAY 1 - 1957

STATE FILE NUMBER  
139

Registration District No. 77 Primary Registration District No. 3016

Registrar's No. 139

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Cole</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jefferson City, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Jefferson City</b> <i>026</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>112 Clay Street</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Cora Elizabeth Wilson</b>			4. DATE OF DEATH Month Day Year <b>April 24, 1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1882</b>		9. AGE (In years last birthday) <b>74</b>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	11. BIRTHPLACE (City and state or country) <b>Osage Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
---	--	---	---	--	--

13a. FATHER'S NAME <b>David Martin</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>James E. Wilson</b>		
---	--	---	---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>James Enoch Wilson Jefferson City, Mo.</b>		
---	--	--------------------------------------	---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				
DUE TO (b)				
DUE TO (c)				

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>arterio-sclerotic heart disease</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---	--	--	--	---

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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		COUNTY	STATE
--	--	------------------------------	--	--------	-------

21. I attended the deceased from <b>Mar 6 1957</b> to <b>April 24 1957</b> and last saw her alive on <b>4/24/57</b> Death occurred at <b>1:30 A</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
---	--	--	--	--	--

22a. SIGNATURE (Degree or title) <b>Frank P. Meier M.D.</b>		22b. ADDRESS <b>507 E High</b>		22c. DATE SIGNED <b>4/26/57</b>	
--	--	-----------------------------------	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 26, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson City, Mo.</b>
--	--	-----------------------------------	---	--	---

24. FUNERAL DIRECTOR ADDRESS <b>Victor Buescher</b>		25. DATE RECD. BY LOCAL REG. <b>Apr 26 1957</b>	26. REGISTRAR'S SIGNATURE <b>R.P. Norris, M.D.</b>		
---	--	--	---	--	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

8 0

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 Victor Buesche

Licensed Embalmer No. 370  
P. O. Address J.C. Ma

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.