

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35601**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **140** PRIMARY REG. DIST. NO. **3024** Registrar's No. **96**

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fayette</b>		c. CITY OR TOWN <b>Fayette</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>20 days</b>		e. STREET ADDRESS (If rural, give location) <b>103 South Linn</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lee Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Edward</b>	b. (Middle) <b>Spencer</b>	c. (Last) <b>Willis</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 20 1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 30 1869</b>	9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>20</b>	IF UNDER 2 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Corder Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Augustus W. Willis</b>	13b. MOTHER'S MAIDEN NAME <b>Susan Eppes</b>	14. NAME OF HUSBAND OR WIFE <b>May Agnes Wilson</b>
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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>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. E.S. Willis</b>	ADDRESS <b>Fayette Mo.</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uremic Coma</b>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (b) <b>Prostatic Obstruction</b>	
		DUPLICATE OF (c) <b>Cystonephritis</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) <b>Fayette Howard Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Oct 1, 1957**, to **Oct 20, 1957**, that I last saw the deceased alive on **Oct 20, 1957**, and that death occurred at **2 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. J. Bloom M.D.</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Fayette Mo</b>	23c. DATE SIGNED <b>10-20-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 22 1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fayette City</b>	24d. LOCATION (City, town, or county) (State) <b>Fayette Missouri</b>
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DATE RECD BY LOCAL REG. <b>10/20/57</b>	REGISTRAR'S SIGNATURE <b>Thayer K. Shell</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph D. Carr</b>	ADDRESS <b>Fayette Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

4360

AUG 26 1959

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 *William C. Trebe*

Licensed Embalmer No. *4870*

P. O. Address *Hayette*

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.