

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-009651
STATE FILE NUMBER

FILED MAR 31 1958

Registration District No. 132 Primary Registration District No. 5480 Registrar's No. 52

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Mo b. COUNTY HARRISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Trenton Sup.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Gilman ⁰⁴¹⁸
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Plainview Rest Home		Length of stay in 1b 1 month	d. STREET ADDRESS (If outside, give location) Gilman
3. NAME OF DECEASED (Type or print) First Middle Last Willis Ogilvia Black			4. DATE OF DEATH Month Day Year 3-20-1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1869
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER Ret F	11. BIRTHPLACE (City and state or country) HARRISON Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Albert R. Black	13b. MOTHER'S MAIDEN NAME Cornelia M. Canon
14. NAME OF HUSBAND OR WIFE Nettie L. Black		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war & dates of service) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Cliva Norris Gilman City	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Senility DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 4500
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 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 2-16-58 to 3-20-58 and last saw her/him alive on 3-2-58 Death occurred at Trenton on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Mrs. A. Mason MD (Degree or title)		22b. ADDRESS Trenton Mo	22c. DATE SIGNED 3-21-58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	3-22-1958	MASONIC	Gilman City Mo
24. FUNERAL DIRECTOR M. Mason Address Bethany Mo		25. DATE RECD. BY LOCAL REG. 3-22-58	26. REGISTRAR'S SIGNATURE Gene Fair

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 *M. S. Jones*

Licensed Embalmer No. *3899*
P. O. Address *Bethany, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.