

Health, Welfare
Public
Service

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Use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 31 1958

58-012853
STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3072 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> <u>1000</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		c. CITY OR TOWN <u>DIEHLSTADT</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Comm. Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Route #2 Charleston</u>	
Length of stay in lb <u>8 Days</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wilson</u> Last <u>Michael</u>			4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>3-16-1883</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant & Farming</u>	11. BIRTHPLACE (City and state or country) <u>Graves Co., Kentucky /</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Richard John/Michael</u>			14. MOTHER'S MAIDEN NAME <u>Rosebelle Watts</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. <u>196 36 6512</u>		17. INFORMANT Address <u>Ada Michael, Charleston, Mo. RFD#2</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>Cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> <u>simple</u> <u>type</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>443 X</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gastro Intest. bleeding - Parkinson's disease</u>		

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.) <u>2</u>		
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a. m. <u> </u> p. m. <u> </u>			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.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE

21. I attended the deceased from <u>2/22/58</u> to <u>3/8/58</u> and last saw ^{her} him alive on <u>3/8/58</u> Death occurred at <u>10:55 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>E. Charles Salway M.D.</u>		22b. ADDRESS <u>Charleston, Mo.</u>	22c. DATE SIGNED <u>3/12/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/10/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maynard Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>RFD#2 Charleston, Mo.</u>
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24. FUNERAL DIRECTOR <u>John J. Nunnelee</u> THE NUNNELEE FUNERAL CHAPEL <u>Charleston, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-22-58</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Elnor Hunter</u>
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DATE RECEIVED MAR 24 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 358-75

APR 10 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John F. Munnelle Jr

Licensed Embalmer No. 38

P. O. Address Charles

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.