

Health,  
& Welfare  
Public  
Service

S. 300  
1-57

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.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024820  
STATE FILE NUMBER

FILED AUG 6 1958 Registration District No. 50 Primary Registration District No. 4072 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <b>Camden</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b>		b. COUNTY <b>Camden</b>		c. LIFE <b>Life</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Linn Creek</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Linn Creek</b>		0150 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Linn Creek, Mo</b>		Length of stay in lb <b>Life</b>		d. STREET ADDRESS <b>Linn Creek</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Susa Wilson</b>			4. DATE OF DEATH Month Day Year <b>July 29 1958</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20- 1873</b>	9. AGE (In years last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days <b>4 9</b>		IF UNDER 24 HRS. Hours Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Camden County Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		

13a. FATHER'S NAME <b>Joe Winfrey</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Amous</b>		14. NAME OF HUSBAND OR WIFE <b>Elbert 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>Oran Wilson Linn Creek, 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>The Intestinal Obstruction caused by rupture of large intestine with perforation</b>		DUE TO (b) <b>Chronic rheumatoid arthritis</b>	DUE TO (c) <b>Intoxic. Schistosom. Cerebral</b>	INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>10 years</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5704</b>				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.) <b>---</b>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>---</b>		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.) <b>---</b>		20f. CITY, TOWN, OR LOCATION <b>---</b>		COUNTY <b>---</b>	STATE <b>---</b>
21. I attended the deceased from <b>June - 1957</b> to <b>July 29 58</b> and last saw her alive on <b>July 28 - 1958</b> . Death occurred at <b>---</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Dr. E. Wayland</b> (Deceased or title)			22b. ADDRESS <b>Camdenton, Mo</b>		22c. DATE SIGNED <b>July 31-58</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 31, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Freedom Cemetery</b>		23d. LOCATION (City, town, or county) <b>Camden County Mo</b>	
24. FUNERAL DIRECTOR <b>Reed Funeral Home Camdenton Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>July 31-1958</b>	26. REGISTRAR'S SIGNATURE <b>Zilpha J. Traver</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Robert H. Reed .....

Licensed Embalmer No. 3745 .....  
P. O. Address Camdenton, 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.