

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043925

STATE FILE NUMBER

FILED JAN 5, 1959

Registration District No. 141 Primary Registration District No. 3553 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worcester</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>South Fork</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>South Fork</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>L.</u> Last <u>Black</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1884</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Worcester Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Simon Black</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, for, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
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>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease conditions given in PART I (a) <u>Arteriosclerosis, gen. Debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 <u>May 14-1962-15-58</u> and last saw her alive on <u>12-12-58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Dwight or title) <u>Jack No. Wiley, M.D.</u>	
22b. ADDRESS <u>West Plains, Mo</u>		22c. DATE SIGNED <u>12-22-58</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE <u>12-18-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d. LOCATION (City, town, or county) (State) <u>South Fork Mo</u>
24. FUNERAL DIRECTOR <u>Cherborn, Mrs. Thoms</u> ADDRESS <u>Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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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 

Licensed Embalmer No. 3437
P. O. Address West Hill

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.