

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-047101  
STATE FILE NUMBER

FILED JAN 20 1959

Registration District No. 140 Primary Registration District No. 5547 Registrar's No. 127

300  
1-57

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>Cooper</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moniteau Twsp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Boonville</b> <b>0270</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Mersey Home</b>		Length of stay in 1b <b>1 Hour.</b>	d. STREET ADDRESS <b>R. F. D. #2</b>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Arzelia S. Clark</b> Middle <b>Wilson</b> Last <b>Wilson</b>			4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1958</b>		
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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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1873</b>	9. AGE (In years last birthday) <b>85</b>	10. FUNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Champaign, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Henry H. Clark</b>	13b. MOTHER'S MAIDEN NAME <b>Ameria Harrison.</b>	14. NAME OF HUSBAND OR WIFE <b>Orah A. 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>-----</b>	17. INFORMANT <b>Mrs. Warner Robertson, Boonville, Mo.</b>	Address
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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>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>
DUE TO (b) <b>Arterio sclerosis</b>		
DUE TO (c) <b>Hypertension</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension</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 type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>None</b>
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20c. TIME OF INJURY Hour <b>9:00</b> Month <b>Dec</b> Day <b>23</b> Year <b>58</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>See 23-58</b>	20f. CITY, TOWN, OR LOCATION <b>Boonville</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from <b>Jan 5 to Dec 23 58</b> and last saw her alive on <b>Dec 1 58</b> Death occurred at <b>9:00 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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21a. SIGNATURE <b>Dr. DeGraeger MD</b>	(Degree or title)	22a. ADDRESS <b>Boonville Mo</b>	22b. DATE SIGNED <b>12/26/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 26/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Grove</b>	23d. LOCATION (City, town, or county) (State) <b>Boonville, Missouri.</b>
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24. FUNERAL DIRECTOR <b>Goodman &amp; Boller, Boonville, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12/26/58</b>	26. REGISTRAR'S SIGNATURE <b>Mary K. Shell</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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 *William W. Wood* .....

Licensed Embalmer No. 4539 .....

P. O. Address Boonville, 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.