

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001793  
STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 157 Primary Registration District No. 6293 Registrar's No. 6

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Washer</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Washer</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sheridan</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Washer</u> <u>6490</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 <u>Route # 1 Washer</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Washer Route # 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Marriett</u> Middle <u>Wynusta</u> Last <u>Wresham</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>5</u> Year <u>1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1874</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Carthage, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. U.</u>
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13a. FATHER'S NAME <u>Werner Washer</u>	13b. MOTHER'S MAIDEN NAME <u>Amanda Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Wresham</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>John Wresham, Washer, Mo. # 1</u> 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) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>  <u>years</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>Chronic pyelonephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from <u>8/2/55</u> to <u>1-5-59</u> and last saw her/him alive on <u>1/4/59</u> Death occurred at <u>9:30</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Charles F. Schell, M.D.</u>	22b. ADDRESS <u>Carthage Mo.</u>	22c. DATE SIGNED <u>1/9/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carthage Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Washer Mo., Mo.</u>
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24. FUNERAL DIRECTOR <u>Werner Funeral Home, Carthage, Mo.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-9-59</u>	26. REGISTRAR'S SIGNATURE <u>E. W. Clenton</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
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.

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 .....  
*Edwin S. Thomas Jr.*

Licensed Embalmer No. *4955*

P. O. Address *Bartholomew*

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.