

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004495

STATE FILE NUMBER

MAR 16 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 117

300
1-57

1. PLACE OF DEATH - a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u> <u>6646</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel</u>		Length of stay in 1b <u>73 days</u>	d. STREET ADDRESS (If outside, give location) <u>809 Vine St.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<u>Wilda</u>	<u>Morine</u>	<u>McDonald</u>	<u>March</u>	<u>12</u>	<u>1959</u>

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1921</u>	9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
--------------------	------------------------------	--	---	--	--	--

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>Novelty, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>Frank Winget</u>	13b. MOTHER'S MAIDEN NAME <u>Lena May Harris</u>	14. NAME OF HUSBAND OR WIFE <u>Roy McDonald</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>496-12-6490</u>	17. INFORMANT <u>Hospital Records</u>	Address
--	---	--	---------

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>Hepatic insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of cervix uteri</u>	<u>unknown</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <u>171X</u>
---	---

20c. TIME OF INJURY Hour <u>9:00</u> Month <u>Dec</u> Day <u>29</u> Year <u>1958</u> a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Hannibal, Missouri</u>	COUNTY <u>Marion</u>	STATE <u>Missouri</u>
--	--	---	-------------------------	--------------------------

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 <u>Hannibal, Missouri</u>	COUNTY <u>Marion</u>	STATE <u>Missouri</u>
---	--	---	-------------------------	--------------------------

21. I attended the deceased from Dec. 29, 1958 to March 12, 1959 and last saw her alive on March 12, 1959
Death occurred at 9:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert M. Weiss, M.D.</u>	22b. ADDRESS <u>EFS Cancer Hosp</u>	22c. DATE SIGNED <u>3-12-59</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>3-13-59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>
---	-----------------------------	------------------------------------	--

24. FUNERAL DIRECTOR <u>PARKER FUNERAL SERVICE</u>	ADDRESS <u>COLUMBIA MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 13, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>
---	-------------------------------------	---	--

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 entered. 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 *George P. Kirby*

Licensed Embalmer No. *4752*

P. O. Address *Columbia, Md.*

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.