

Health, Welfare, Public Service

300  
-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006669  
STATE FILE NUMBER

FILED MAR 4 1959

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 24

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>PIKE</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>PIKE</b>                     |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>LOUISIANA</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>NEW HARTFORD</b>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>PIKE COUNTY HOSPITAL</b>   |  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>NELLIE MAY WILHOIT</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>FEB. 25, 1959</b>   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov 17, 1882</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>76</b><br>IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS.                               |
| 11. BIRTHPLACE (City and state or country)<br><b>PIKE COUNTY, MO.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>JAMEST. WILLIS</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>RHODA ANN <del>WILHOIT</del></b>  | 14. NAME OF HUSBAND OR WIFE<br><b>WILLIAM WILHOIT</b>  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>—</b>   | 17. INFORMANT<br>Address<br><b>WAYLAND WILHOIT, NEW HARTFORD, MO</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hydrocephalus</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Anemia</b>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>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.)  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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   |
| 21. I attended the deceased from <b>Sept. 1938</b> to <b>July 24, 1959</b> and last saw her alive on <b>2. 24/59</b><br>Death occurred at <b>10:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>G. L. Bilgus D.O. 2</b>   |  | 22b. ADDRESS<br><b>Louisiana Mo</b>   | 22c. DATE SIGNED<br><b>2/24-59</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>FEB. 27, 1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SILOAM CEMETERY</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>PIKE COUNTY MISSOURI</b>   |
| 24. FUNERAL DIRECTOR<br><b>GRACE BANKHEAD BOWLING GREEN MOTEL</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>28-59</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Bernice Collier</b>  |

(Licensed Embalmer's Statement on Reverse Side)

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 *Harold C. Kirke* .....

Licensed Embalmer No. *4597* .....

P. O. Address *Bowling Green* .....

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.