

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008531

STATE FILE NUMBER 293

FILED MAR 30 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No.

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-57 2

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Rushville</i> <i>0110</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hosp No 2</i>		Length of stay in lb <i>24 11 20 today</i>	d. STREET ADDRESS (If outside, give location) <i>Rural</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Oliver</i> Last <i>Wilson</i>			4. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1959</i>			
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25 1879</i>	9. AGE (In years last birthday) <i>79</i>	IF UNDER 1 YEAR Months <i>7</i> Days <i>23</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (City and state or country) <i>Buchanan Co Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
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13a. FATHER'S NAME <i>James Wilson</i>	13b. MOTHER'S MAIDEN NAME <i>Sarah Marsh</i>	14. NAME OF HUSBAND OR WIFE <i>Hallie May Wilson</i>
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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) <i>no</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Truman J. Wilson</i>	Address <i>1209 So 14 St for Mo</i>
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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) <i>Chronic Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Present on admission</i>
DUE TO (b) <i>Yersingel Arteriosclerosis</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <i>4321</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chr Brain Syndrome associated with Senile Brain Disease</i>		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <i></i> Month <i></i> Day <i></i> Year <i></i> a.m. <i></i> p.m. <i></i>	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 <i>April 1 1956</i> to <i>March 18 59</i> and last saw her/him alive on <i>March 18 1959</i> Death occurred at <i>5:35 PM</i> 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) <i>Forrest Thomas M.D.</i>	22b. ADDRESS <i>Appt Mo 7 State Hosp No 2</i>	22c. DATE SIGNED <i>3-18-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Mar. 21 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sugar Creek Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Rushville Mo.</i>
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24. FUNERAL DIRECTOR <i>Sawin Dyer</i>	ADDRESS <i>Atchison, Kansas</i>	25. DATE RECD. BY LOCAL REG. <i>Mar. 23 1959</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>
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MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 DR. FORREST THOMAS  
 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  .....

Licensed Embalmer No. 4320 .....

P. O. Address Atchafalaya, La.

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.