

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012624

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1-57

FILED MAY 7 1959 Registration District No. 59 Primary Registration District No. 4097 STATE FILE NUMBER 88 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY CAS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HARRISONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN HARRISONVILLE 0191 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTE 3027. Independence		Length of stay in 8 months	d. STREET ADDRESS (If outside, give location) 3027. Independence Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HOWARD Middle LEE Last WILLS			4. DATE OF DEATH APRIL 28, 1959		
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 30-1892	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Lineman		10b. KIND OF BUSINESS OR INDUSTRY Telephone	11. BIRTHPLACE (City and state or country) HARRISONVILLE, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas J. WILLS		13b. MOTHER'S MAIDEN NAME ANNA MARIE Harsh Berger		14. NAME OF HUSBAND OR WIFE ABBIE WILLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 487-16-9487-A		17. INFORMANT Address Mrs ABBIE WILLS HARRISONVILLE, MO.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4341		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.)	
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 HARRISONVILLE, Mo.	COUNTY	STATE
21. I attended the deceased from Nov 28, 1958 to Apr 28 and last saw him alive on Apr. 28, 1959 Death occurred on Apr. 28 at 8:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Paul H. Green D.O.		22b. ADDRESS HARRISONVILLE, Mo.	22c. DATE SIGNED 5-2-59
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-30-1959	23c. NAME OF CEMETERY OR CREMATORY WILLS CEMETERY	23d. LOCATION (City, town, or county) (State) PECULIAR, MISSOURI

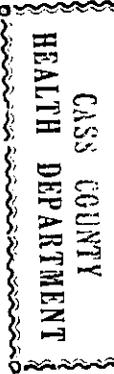
24. FUNERAL DIRECTOR Atkinson - D. Key	ADDRESS HARRISONVILLE, Mo.	25. DATE RECD. BY LOCAL REG. 5-4-59	26. REGISTRAR'S SIGNATURE Mrs Ray Sebrae
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

every county, etc. must use only standard nomenclature in year 16. No symptoms with or without. All diseases in Part I must be causally related.

MAY 29 1959



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 *Robert W. Johnson*

Licensed Embalmer No. *4902*
P. O. Address *Johnsonville, Tenn.*

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.