Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-016874
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 549

1. PLACE OF DEATH a. COUNTY Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Nebr. b. COUNTY Lancaster
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Lincoln — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Josephs Hosp. — Length of stay in 1b: 1 day	d. STREET ADDRESS (If outside, give location) 2441 S. 10th — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
WILBUR	C.	STALEY	May 22, 1959

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
male	white	MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	June 9, 1877	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
unknown		unknown	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
unknown	unknown	unknown

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.	17. INFORMANT Address
unknown	unknown	Mrs. Betty Firestone, Box 85, Fountain, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451K

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 5:00 a.m. 5-22-59, to 8:40 a.m. 5-22-59 and last saw him alive on 5-22-59

Death occurred at 8:40a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
E. F. Butler M.D.	902 Edmond, St. Joseph, Mo.	5-22-59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
removal	5/22/1959		Panama City, Fla.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Heaton-Bowman	St. Joseph, Mo.	May 25, 1959	Mrs. Clark Hardell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. E.F. Butler

No Embalm

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St Joseph

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.