

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017033  
STATE FILE NUMBER

FILED MAY 28 1959 Registration District No. 5-9 Primary Registration District No. 4097 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Pleasant Hill</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Length of stay in lb <u>2 days</u>		d. STREET ADDRESS <u>925 N. Taylor</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>PATRICIA MAE WILSON</u>			4. DATE OF DEATH Month Day Year <u>May 17 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15-1959</u>
9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Harrisonville Mo. USA</u>	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>W. H. Wilson</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Roberts</u>		14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>	
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>NONE</u>	
17. INFORMANT <u>William H. Wilson</u> Address <u>Pleasant Hill Mo</u>		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>ATELECTASIS, POSTNATAL</u> 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) <u>7620</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 <u>Month, Day, Year</u> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>May 15 1959</u> to <u>May 17 1959</u> and last saw her <u>live on May 17, 1959</u> Death occurred at <u>11:35</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>O. J. Bargen M.D.</u> (Degree or title)		22b. ADDRESS <u>Harrisonville Mo</u>	
22c. DATE SIGNED <u>18 May 1959</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>May 18-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Harrisonville Mo.</u>		24. FUNERAL DIRECTOR <u>Rennenburgers</u> ADDRESS <u>Harrisonville Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>May-18-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Ray Sebee</u>	

Doctor, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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

*Infant - not embalmed*

Signed .....

*Ernest Rummelberger*

Licensed Embalmer No. *3368*

P. O. Address *Harrisonville*

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.