

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020245

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No.

374

Primary Registration District No.

Registrar's No.

18

1. PLACE OF DEATH a. COUNTY Worth County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) Middle Fork Township		c. CITY OR TOWN Worth Missouri	
c. FULL NAME OF (If NOT in hospital, give location) North-east of Denver 2-weeks		d. STREET ADDRESS (If outside, give location) North part of Worth	
3. NAME OF DECEASED (Type or print) William A. Pickering		4. DATE OF DEATH Month April Day 24 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH February-23-1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		11. BIRTHPLACE (City and state or country) Chucky Tennessee	
13a. FATHER'S NAME Williwm Alexander Pickering		14. NAME OF HUSBAND OR WIFE Mary Alice Pickering	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT John Pickering Denver Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1) Prostatic Hypertrophy with Urinary Retention		INTERVAL BETWEEN ONSET AND DEATH 5yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 610X	
20c. TIME OF INJURY Hour a.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT ☐ 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 Grant City, Mo	
21. I attended the deceased from 1950 to april 24 59 and last saw her alive on 23Apr 59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Frank B Matteson M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 26-59	
23c. NAME OF CEMETERY OR CREMATORY Prairie Chapel Cemetery		23d. LOCATION (City, town, or county) (State) Denver Mo	
24. FUNERAL DIRECTOR John Andrews		25. DATE RECD. BY LOCAL REG. June 11-1959	
26. REGISTRAR'S SIGNATURE Bowdoy Kibbe		27. DATE RECD. BY LOCAL REG. June 11-1959	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

6081 6 7 NOV

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 John Andrews, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John Andrews.....

Licensed Embalmer No. 4211.....

P. O. Address Grant City, Mo......

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.