

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021110

FILED JUN 22 1959

Registration District No. 137 Primary Registration District No. 3025 Registrar's No. 108

STATE FILE NUMBER

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u> | | c. CITY OR TOWN <u>Clinton</u> | |
| Length of stay in 1b <u>15 days</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>Clinton Gen. Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>315 North Water</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EARL WHITWORTH</u> | | | 4. DATE OF DEATH Month Day Year <u>JUNE 19 1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-17-1882</u> | 9. AGE (last birthday) <u>77</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>taxi cab operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>taxi cab</u> | | 11. BIRTHPLACE (City and state or country) <u>Shoonee mound Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>W.E. Whitworth</u> | | 13b. MOTHER'S MAIDEN NAME <u>Moyetta Trasker</u> | | 14. NAME OF HUSBAND OR WIFE <u>Sara M Whitworth</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>495-40-2672</u> | | 17. INFORMANT Address <u>Sara M Whitworth Clinton Mo</u> | | |

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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: | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Acute Cardiac dilatation</u> | | | | <u>12 hrs</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | DUE TO (b) <u>Post-operative gastroectomiy + gastroenterostomy</u> <u>2 wks</u> | |
| DUE TO (c) <u>Basilar ulcer</u> | | | | <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u> | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |

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|---|---|--|------------------------------|--------|-------|
| 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 a.m. p.m. Month, Day, Year | 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 |

21. I attended the deceased from 1954 to 6/19/59 and last saw him alive on 6/18/59
Death occurred at 12:10 A 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) <u>S.B. Hughes, M.D.</u> | | 22b. ADDRESS <u>Clinton, Mo.</u> | | 22c. DATE SIGNED <u>6/19/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>6-21-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Englewood</u> | 23d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u> | |
| 24. FUNERAL DIRECTOR'S ADDRESS <u>SCHABERG FUNERAL HOME Clinton</u> | | 25. DATE RECD. BY LOCAL REG. <u>6-19-59</u> | 26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. L. Schaberg

Licensed Embalmer No. 451

P. O. Address Cleveland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.