

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024547

FILED VS AUG 1 0 1959

STATE FILE NUMBER

Registration District No. 27 Primary Registration District No. 5295 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLINTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PLATTSBURG</u>		c. CITY OR TOWN <u>CAMERON MO</u>	
Length of stay in 1b <u>1 yr.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WARREN NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>-</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES FRANKLIN WILLS</u>			4. DATE OF DEATH Month Day Year <u>July 30 59</u>				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MCH 2 1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer + Stone Mason.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME.</u>		11. BIRTHPLACE (City and state or country) <u>Stewartsville</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J.W. Wills</u>		13b. MOTHER'S MAIDEN NAME <u>JANE HAYTON</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>EARL WILLS Cameron MO.</u>			

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>Peripheral vascular collapse</u>			<u>2 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary occlusion</u>		<u>5 min.</u>
	DUE TO (c) <u>Arterio Sclerosis</u>		<u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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

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 8/1/58 to 7/30/59 and last saw ^{her}him alive on 7/28/59
Death occurred at 7:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>R. Baerman D.O.</u>		22b. ADDRESS <u>Lathrop, Mo.</u>		22c. DATE SIGNED <u>7/30/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 2-59.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Osbourn. Cemetery, Osborn</u>		23d. LOCATION (City, town, or county) (State) <u>MO.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robert Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Aug-6-1959</u>		26. REGISTRAR'S SIGNATURE <u>Mary H. Scarsa</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Robert F. Polak

Licensed Embalmer No. 4777
222 UNIT 3

P. O. Address Cameron

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.