

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024577

FILED VS AUG 14 1959 ^{REG} 77

Registration District No. _____ Primary Registration District No. 3016 Registrar's No. 229

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Cole</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u> | | c. CITY OR TOWN <u>Jefferson City</u> | |
| Length of stay in 1b | | 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>310 Locust Street</u> | | d. STREET ADDRESS (If outside, give location) <u>310 Locust Street</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>MRS. LEORA ANDERS WRISTON</u> | | | 4. DATE OF DEATH Month Day Year <u>August 13, 1959</u> | | |
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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>5-27-1873</u> | 9. AGE (last birthday) <u>86</u> | IF UNDER 1 YEAR Months <u>2</u> Days <u>17</u> Hours _____ Min. _____ | IF UNDER 24 HR Hours _____ Min. _____ |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housekeeper</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u> | 11. BIRTHPLACE (City and state or country) <u>Aldridge, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>John Lyman</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Thomas J. Wriston</u> |
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| 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>No</u> | 17. INFORMANT Address <u>Miss Helen L. Wriston 310 Locust J.C., 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: IMMEDIATE CAUSE (a) <u>Carcinoma of transverse colon</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</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) | | 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year |
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|---|--|------------------------------|--------|-------|
| 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 April 1959 to Aug. 13, 1959 and last saw her alive on Aug 12, 1959
Death occurred at 2:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Robert H. Lanney, M.D.</u> (Degree or title) | 22b. ADDRESS <u>Jefferson City, Mo.</u> | 22c. DATE SIGNED <u>8-14-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 15, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Victor Buescher, J.C. Mo.</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>14 August 1959</u> | 26. REGISTRAR'S SIGNATURE <u>R. P. Norris, M.D. MR.</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

113 537

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Victor Buesch

Licensed Embalmer No. 376

P. O. Address JCM

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