

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032904

FILED VS OCT 13 1959

Registration District No. 170 Primary Registration District No. — Registrar's No. 146

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Conway</u>		Length of stay in 1b <u>1 mo.</u>		c. CITY OR TOWN <u>Conway</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>Conway mo.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <u>no st. address</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Stella D.</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>5</u> Year <u>1959</u>					
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>12/26/1887</u>		9. AGE (last birthday) <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co. Mo. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME <u>Robert Allen</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Hobbs</u>			14. NAME OF HUSBAND OR WIFE <u>Arthur</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>none</u>		17. INFORMANT <u>Venus Howerton Conway mo.</u> Address				
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>Cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Vascular Disease</u>							8-10 yrs.		
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>Diabetes Mellitus</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>—</u> a.m. <u>—</u> p.m. <u>—</u>		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 <u>1958</u> to <u>death</u> and last saw her <u>alive</u> on <u>April 1959</u> Death occurred at <u>3: A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>W. Frolich, Jr.</u> (Degree or title)				22b. ADDRESS <u>Lebanon Mo</u>				22c. DATE SIGNED <u>10/6/59</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/7/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lonesome Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Laclede Co. Mo.</u>			
24. FUNERAL DIRECTOR <u>Dorsey M. Howe</u> ADDRESS <u>Lebanon Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>10-6-1959</u>		26. REGISTRAR'S SIGNATURE <u>Stella L. Day</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 Dorsey M. Hou

Licensed Embalmer No. 422

P. O. Address Lebanon

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.