

FEDERAL BUREAU OF INVESTIGATION FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036966

STATE FILE NUMBER

FILED VS. NOV 3 1959 234

Registration District No. _____ Primary Registration District No. 5814 Registrar's No. 3

ENDED

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buffalo Township</u>		Length of stay in 1b <u>1 Year</u>		c. CITY OR TOWN <u>Versailles, Mo.</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>10 N. S. W. Versailles</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>10 N. S. W. Versailles</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First - <u>Mary</u> Middle - <u>Olive</u> Last - <u>Wernolds</u>						4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1959</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</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>9-19-1876</u>		9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
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>None</u>				11. BIRTHPLACE (City and state or country) <u>Ada, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. i.</u>			
13a. FATHER'S NAME <u>John Firestone</u>				13b. MOTHER'S MAIDEN NAME <u>Matilda J. Stull</u>				14. NAME OF HUSBAND OR WIFE <u>Clude Wernolds</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 Address <u>Mrs Irene Hammerle Versailles, Mo.</u>							
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>Cerebrovascular Accident</u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Upper Respiratory Infection</u>										<u>3 days</u>			
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>Chronic Glaucoma, Abdominal Aortic Aneurysm</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 _____ s.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 <u>1958</u> to <u>Oct. 28, 1959</u> and last saw her ^{her} him alive on <u>Oct 28, 1959</u>													
Death occurred at <u>30 m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Ray Lyle, M.D.</u>						22b. ADDRESS <u>Versailles, Missouri</u>				22c. DATE SIGNED <u>10-29-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>30 Oct. 59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dwight Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Dwight, Kansas</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Lidwell Funeral Home Versailles, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>Oct. 29, 1959</u>					26. REGISTRAR'S SIGNATURE <u>Wm. E. Ripberger</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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Newville, Pa.

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.