URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-040467

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5438

ENDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in Ib 2 Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1225 W. 68 Terr
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY LaFayette
c. CITY OR TOWN Odessa
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS X (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Elizabeth Middle: Susan Last: Wilkinson
4. DATE OF DEATH Month: Nov Day: 7 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: Dec 31, 1866
9. AGE (last birthday): 93
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: —
13b. MOTHER'S MAIDEN NAME: —
14. NAME OF HUSBAND OR WIFE: Benjamin M. Wilkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 440-42-5791A
17. INFORMANT: Husman-Sparks, Address: Odessa Mo.

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)	Myocardial Degeneration	1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	1 year
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. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 May 1, 1958 to Nov. 7, 1959 and last saw her/him alive on Nov. 7, 1959
Death occurred at 1:05 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John K. Caldwell (Degree or title) MD
22b. ADDRESS 306 E 12 St. Kansas City, Mo.
22c. DATE SIGNED 11/7/59

BY AFFIDAVIT OF John K. Caldwell

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11-11-59
23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery
23d. LOCATION (City, town, or county) Odessa (State) Mo.

24. FUNERAL DIRECTOR Husman-Sparks ADDRESS Odessa, Mo.
25. DATE REC'D BY LOCAL REG. 11-11-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed William T. Sparks

Signature of Student Embalmer

Licensed Embalmer No. 493

P. O. Address Odessa

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