URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

'59 043308
STATE FILE NUMBER

FILED VS DEC 22 1959

MENDED

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 83

1. PLACE OF DEATH
a. COUNTY Bollinger Co.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lutesville Mo
Length of stay in 1b: 21 Da.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Bond Nursing Home
Inside Limits: Yes ☒ No ☐

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

3. NAME OF DECEASED (Type or print): First Henry Middle William Albert Last Wessell
4. DATE OF DEATH: Month Nov, Day 30 Year 1959
5. SEX: M.
6. COLOR OR RACE: W.
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-24-59
9. AGE (last birthday): 86
IF UNDER 1 YEAR: Months 0 Days 6 IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Gordonville Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: August Wessell
13b. MOTHER'S MAIDEN NAME: Loresia Ode
14. NAME OF HUSBAND OR WIFE: Lillie Muster
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Albert Wessell Address: Gordonville Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinomatosis
DUE TO (c) Primary submandibular gland
INTERVAL BETWEEN ONSET AND DEATH
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
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 11/20/59, to 11/30/59 and last saw ~~her~~ him alive on 11/30/59
Death occurred at 1:40 pm m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE John J. Myers (Degree or title) MD
22b. ADDRESS Lutesville Mo
22c. DATE SIGNED 12/5/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-3-59
23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran
23d. LOCATION (City, town, or county) (State) Near Gordonville Mo.
24. FUNERAL DIRECTOR Deneke- Laird ADDRESS Jackson Mo.
25. DATE RECD. BY LOCAL REG. 12-15-59
26. REGISTRAR'S SIGNATURE Mrs. Buford Crader

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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_____ Signed R. O. Laird

Signature of Student Embalmer

Licensed Embalmer No. 4538

P. O. Address Jackson, Mo.

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