

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002310

FILED VS. JAN 26 1960 170

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 13

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Phillipsburg</u>		Length of stay in lb <u>39 yrs</u>		c. CITY OR TOWN <u>Phillipsburg</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>Rt # 1</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>R.R. # 1.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Marie Wilson</u>				4. DATE OF DEATH Month Day Year <u>Jan. 17, 1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</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>3/3/1920</u>	9. AGE (as birthday) <u>39</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
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>Morgan, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Phillip Peters</u>			13b. MOTHER'S MAIDEN NAME <u>Della Mace</u>			14. NAME OF HUSBAND OR WIFE <u>Roy C. Wilson</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>493-16-8472</u>		17. INFORMANT <u>Roy C. Wilson Phillipsburg 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>METASTATIC ADENOCARCINOMA, GENERALLY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>From BREAST, Post-OP - 7 yrs</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <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 a.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>MARCH 1959</u> to <u>DEC 1959</u> and last saw her alive on <u>31 DEC. 1959</u> Death occurred at <u>10:50 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>J. H. Allen M.D.</u>				22b. ADDRESS <u>Springfield Mo</u>			22c. DATE SIGNED <u>1-19-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lonesome Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laclede Co. Mo.</u>				
24. FUNERAL DIRECTOR <u>D. M. Howe Lebanon, Mo.</u>			ADDRESS <u>1-20-1960</u>		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE <u>Della L. May</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. How

Licensed Embalmer No. 422

P. O. Address Lebanon

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