

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN 13 1960

-60-002605

Registration District No. 231 Primary Registration District No. 4348 Registrar's No. 3 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Montg</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wellsville</u>		Length of stay in 1b <u>6 days</u>	c. CITY OR TOWN <u>Middletown Mo.</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>Otis Lemasters Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Delena</u> Last <u>Wilhoit</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>F</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>Feb 25 1880</u>	9. AGE (last birthday) <u>79</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>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Pike Co Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>William Fisher</u>		13b. MOTHER'S MAIDEN NAME <u>Etna Cramer</u>		14. NAME OF HUSBAND OR WIFE <u>George M Wilhoit</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>Rona Lemasters, Wellsville, 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>Apoplexy</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u>		
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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"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 10/31/59 to 1/4/60 and last saw her alive on 1/4/60
 Death occurred at 1/4/60, 11:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Willis H. Walls MD.</u>		22b. ADDRESS <u>Wellsville Mo</u>		22c. DATE SIGNED <u>1/6/60</u>
23a. BURIAL, CREMATIONS, REMOVALS (Specify) <u>Jan 7 1960</u>	23b. DATE <u>Jan 8 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairmount Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Middletown Mo</u>	

24. FUNERAL DIRECTOR'S ADDRESS <u>W.O. Pritchett - Middletown Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 9 - 1960</u>	26. REGISTRAR'S SIGNATURE <u>Laura B Callaway</u>
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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 George O. Hagner

Licensed Embalmer No. 3773

P. O. Address Louisiana,

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.