

# R1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

**-60-005151**

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 127

1. PLACE OF DEATH a. COUNTY <b>Boone</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Length of stay in 1b <b>Lifetime</b>		c. CITY OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>902 Worley St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>902 Worley St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>VELPO</b> Last <b>WHITESIDES</b>				4. DATE OF DEATH Month <b>February</b> Day <b>29</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-27-1888</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Funeral Director</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Funeral Director</b>		11. BIRTHPLACE (City and state or country) <b>Boone Co., Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>William Whitesides</b>			13b. MOTHER'S MAIDEN NAME <b>Alice Crowe Rowland</b>			14. NAME OF HUSBAND OR WIFE <b>Lila Dinkle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>490-07-0835</b>		17. INFORMANT Address <b>Mrs. W.V. Whitesides, Columbia, Mo.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>							<b>unknown</b>		
DUE TO (c) <b>Arteriosclerosis Generalized</b>							<b>unknown</b>		
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>1-26-54</b> to <b>2-29-60</b> and last saw <sup>him</sup> alive on <b>2-29-60</b> Death occurred at <b>12:15</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Charles M. Fawke, M.D.</b> (Degree or title)				22b. ADDRESS <b>Columbia, Missouri</b>			22c. DATE SIGNED <b>2-29-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Mar. 1, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) <b>Columbia, Mo.</b>			(State)	
24. FUNERAL DIRECTOR <b>Parker Funeral Service, Columbia, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Feb. 29, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. R.E. Palmer</b>			

(Licensed Embalmer's Statement on Reverse Side)

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 Donald L Roberts

Licensed Embalmer No 4922

P. O. Address Columbia M

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.