

Dr. R. R. Wilson
JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 19 1960

-60-020141

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 191

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Marion</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b		c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clark's Nursing Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1112 Lindell</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>R.</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1960</u>									
5. SEX <u>Male</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>8-3-1893</u>		9. AGE (last birthday) <u>76</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>Shoe Worker-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Plant</u>		11. BIRTHPLACE (City and state or country) <u>Shelby Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Moses Wilson</u>				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE <u>Elva 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.		17. INFORMANT Address <u>Mrs. Elva Wilson, 1112 Lindell</u>							
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>Generalized metastasis from sarcoma left clavicle</u> DUE TO (b) 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 months</u>					
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 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>4/26/60</u> to <u>4/30/60</u> and last saw him alive on <u>4/30/60</u> Death occurred at <u>6:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <u>2910 St. Marys Ave., Hannibal, Mo.</u>				22c. DATE SIGNED <u>5/13/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5/13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Clarence Cemetery</u>		23d. LOCATION (City, town, or county) <u>Clarence, Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>H.M.O'Donnell, Hannibal, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>5/16/60</u>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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

JM McDonnell

Licensed Embalmer No. 3889

P. O. Address Hannibal,

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.