

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034007

STATE FILE NUMBER

Registration District No. **XC-888165 REG-408A2684**

Primary Registration District No. **2007** Registrar's No. **516**

FILED VS. SEP 26 1960

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MISSISSIPPI</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>			Length of stay in 1b <b>58 DAYS</b>		c. CITY OR TOWN <b>CHARLESTON</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>VETERANS ADMINISTRATION</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>315 SOUTH 3RD STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>WINFIELD</b> Last <b>WILLARD, SR.</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-27-94</b>	9. AGE (last birthday) <b>65</b>	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) <b>GENERAL ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (City and state or country) <b>CHARLESTON, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>CHARLEY WILLARD, SR.</b>			13b. MOTHER'S MAIDEN NAME <b>NANNY LOCKER</b>			14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>486202028</b>		17. INFORMANT (SISTER) Address <b>NANCY POWER, 315 S. 3RD ST., CHARLESTON, 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>LIVER ABSCESS.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>2. DUE TO CIRRHOSIS OF LIVER (LAENNEC'S)</b>						<b>UNKNOWN</b>	
<b>3. DUE TO MULTIPLE OMENTAL ADHESIONS.</b>						<b>3 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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. // attended the deceased from <b>July 4, 1960</b> to <b>August 31, 1960</b> and last saw her <b>alive</b> on <b>VA</b> Death occurred <b>855AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. <b>C. W. GASKINS</b> (Degree or title) <b>Chief, Surgical Svc.</b>				22b. ADDRESS <b>VA Hospital, Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>9/2/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		23d. LOCATION (City, town, or county) (State) <b>Charleston, Mo.</b>	
24. FUNERAL DIRECTOR <b>Mc Mickle Charleston, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-12-60</b>		26. REGISTRAR'S SIGNATURE <i>R. M. Mittlee</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 Elmer McTrotter

Licensed Embalmer No. 4695

P. O. Address Charleston

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.