

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 27 1961

-61-002153

AMENDED

Registration District No. 182 Primary Registration District No. 4296 Registrar's No. 3

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|  |   |  |   |  |  |  |   |
|--|---|--|---|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Linn</b>   |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Linn</b> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Browning</b>  |   | Length of stay in 1b   |   | c. CITY OR TOWN <b>Browning</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION  |   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)                            |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alta</b> Middle <b>Wilhite</b> Last  |   |  |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>19</b> Year <b>61</b>  |  |  |   |
| 5. SEX <b>fe</b>   | 6. COLOR OR RACE <b>W</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>9/1/1900</b>   | 9. AGE (last birthday) <b>60</b>   | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HR<br>Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |   | 11. BIRTHPLACE (City and state or country) <b>Missouri</b>   |  | 12. CITIZEN OF WHAT COUNTRY <b>USA</b>   |   |
| 13a. FATHER'S NAME <b>Charles E. Stults</b>  |   |  | 13b. MOTHER'S MAIDEN NAME <b>Hattie Kimbrough</b>                         |  |  | 14. NAME OF HUSBAND OR WIFE  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |   | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |   | 17. INFORMANT <b>Betty Gray</b>  |  | Address <b>Browning, Mo</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>   |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |   |  | DUE TO (b)  |  | 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____<br>a.m. _____<br>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>1/10/61</b> to <b>1/19/61</b> and last saw her alive on <b>1-18-1961</b><br>Death occurred at <b>4:20 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |  |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>J.R. Martus M.D.</b>  |   |  |   | 22b. ADDRESS<br><b>Browning Mo</b>   |  | 22c. DATE SIGNED<br><b>1/21/61</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   | 23b. DATE<br><b>1/22/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Morris Chapel</b>                |  | 23d. LOCATION (City, town, or county) (State)<br><b>Purdin Rural Mo.</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>Wade Funeral Home</b>   |   |  | ADDRESS<br><b>Browning</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>1-25-61</b>                           | 26. REGISTRAR'S SIGNATURE<br><b>Hurstardwife M.D.</b>  |   |

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Quail F. Wady

Licensed Embalmer No. 4172

P. O. Address Browning

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.