

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013057

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 2012 Registrar's No. 43

AMENDED **FI** **ED** MAY 8 1961

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| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>DALLAS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>EXCELSIOR SPRINGS</u> | | c. CITY OR TOWN <u>ADEL</u> | |
| Length of stay in 1b <u>4 DAYS</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>EXCELSIOR MEDICAL CLINIC</u> | | d. STREET ADDRESS (If outside, give location) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>OTTO</u> Last <u>WILKIE</u> | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1961</u> |
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| 5. SEX <u>MALE</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>7-15-1895</u> | 9. AGE (last birthday) <u>75</u> | IF UNDER 1 YEAR - IF UNDER 24 HR Months Days Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u> | 11. BIRTHPLACE (City and state or country) <u>CLAYTON, COUNTY IOWA</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME <u>AUGUSTA</u> | 14. NAME OF HUSBAND OR WIFE <u>ANNA M VEVERKA</u> |
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| 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 <u>JAMES WILKIE, EARLHAM, IOWA</u> Address |
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| 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>Coronary rupture & Cardiac Failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>45 Minutes</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Senile Cardiac degeneration</u> | |
| | DUE TO (c) | |

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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 type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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| 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 |
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21. I attended the deceased from April 19, 1961 to Date 4/22 and last saw him alive on April 22, 1961
Death occurred at 7:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>James L. Holmes D.O.</u> (Degree or title) | 22b. ADDRESS <u>Excelsior Springs, MO 212 Cliff Drive</u> | 22c. DATE SIGNED <u>4/22/61</u> (State) |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>4-22-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>EARLHAM</u> | 23d. LOCATION (City, town, or county) <u>EARLHAM, IOWA</u> |
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| 24. FUNERAL DIRECTOR <u>FISHER FUNERAL HOME, ADEL, IOWA</u> | 25. DATE RECD. BY LOCAL REG. <u>5-2-61</u> | 26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

VS MAY 9 1961

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

Ralph E. Van Landingham

Licensed Embalmer No. 4009

P. O. Address

Frederic Springs, Pa.

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.