

## OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013450

STATE FILE NUMBER

Registration District No. 128Primary Registration District No. 200Registrar's No. 392B

AMENDED

FILED MAY 8 1961

|  |  |   |  |   |   |  |   |  |                                    |  |  |                              |  |
|--|--|---|--|---|---|--|---|--|------------------------------------|--|--|------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Greene</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>                   |   |  |   |  |                                    |  |  |                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN<br><b>Springfield</b>  |  | Length of stay in 1b  |  | c. CITY OR TOWN<br><b>Springfield</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |                                    |  |  |                              |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>St. Johns Hospital</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>1824 N. Glenstone</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |                                    |  |  |                              |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First<br><b>MARY</b><br>Middle<br><b>RUTH</b><br>Last<br><b>WESCOTT</b>  |  |   |  | 4. DATE OF DEATH<br>Month<br><b>April</b><br>Day<br><b>16,</b><br>Year<br><b>1961</b>   |   |  |   |  |                                    |  |  |                              |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>23 March 1911</b>   |   | 9. AGE (last birthday)<br><b>50</b>                  |                                    | IF UNDER 1 YEAR<br>Months Days   |  | IF UNDER 24 HR<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Secretary-Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hardware Store</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b>                        |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>            |                                    |  |  |                              |  |
| 13a. FATHER'S NAME<br><b>James Jones</b>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Dora Benson</b>   |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Ben R. Wescott</b> |                                    |  |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>No</b>  |   | 17. INFORMANT<br>Address<br><b>Ben R. Wescott (Husband) Springfield, 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>suicition</b>   |  |   |  |   |   |  |   |  |                                    | INTERVAL BETWEEN ONSET AND DEATH   |  |                              |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Adeno-Carcinoma of Biliary system</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"/> No <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>s.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>Jan 31, 1961</b> to <b>4/16/61</b> and last saw her <b>live on 4/16/61</b><br>Death occurred at <b>11:40</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |   |  |                                    |  |  |                              |  |
| 22a. SIGNATURE<br><b>G.B. Terrell M.D.</b><br>(Degree or title)  |  |   |  |   |   | 22b. ADDRESS<br><b>Springfield, Missouri</b>   |   |  | 22c. DATE SIGNED<br><b>4/27/61</b> |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>19 April 1961</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Montier Cemetery</b>   |   | 23d. LOCATION (City, town, or county)<br><b>Montier, Missouri</b>                    |   | (State)  |                                    |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br><b>KLINGNER MORTUARY, INC. Springfield, Mo.</b><br>ADDRESS   |  |   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>5-1-61</b>                             |  | 26. REGISTRAR'S SIGNATURE<br><b>Effie G. Weller</b>                                   |  |                                    |  |  |                              |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INSTEAD OF

ITEM NO. SHOULD READ

jhc

(Licensed Embalmer's Statement on Reverse Side)

MAY 26 1961

OCT 31 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 John B. Klunzner Jr.

Licensed Embalmer No. 5702

P. O. Address SPRINGFIELD

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.