

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-014755

STATE FILE NUMBER

AMENDED

Registration District No. 290

Primary Registration District No.

Registrar's No. 47

FILED MAY 10 1961

1. PLACE OF DEATH

a. COUNTY

Pulaski

b. CITY (If outside corporate limits, give TOWNSHIP only)

Ft Leonard Wood

Length of stay in lb

2 hrs

c. FULL NAME OF (If NOT in hospital, give location)

U S Army Hospital

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri

b. COUNTY Pulaski

c. CITY

Crocker

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

Stump St

(If outside, give location)

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

William

Calvin

York

4. DATE OF DEATH

Month

Day

Year

April

11 1961

5. SEX

Male

6. COLOR OR RACE

White

7. Married

Widowed ☒

Never Married

Divorced ☐

8. DATE OF BIRTH

Sept 9 1904

9. AGE (last birthday)

56

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Pulaski Co Mo

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

George Calvin York

13b. MOTHER'S MAIDEN NAME

Libby Griffin

14. NAME OF HUSBAND OR WIFE

Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

UNKNOWN

17. INFORMANT

Roy C York

Address

Laquey Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

Hypertensive Hemorrhage of Cerebrum
Hypertensive Cardiovascular Disease unknown

INTERVAL BETWEEN ONSET AND DEATH

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.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.
p.m.

20d. INJURY OCCURRED WHILE AT WORK

☐

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 0820 11 April 1961 to 0824 11 April 1961 and last saw him alive on 11 April 1961
Death occurred at 0824 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

U S Army Hospital

22c. DATE SIGNED

11 April 1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

4/14/61

23c. NAME OF CEMETERY OR CREMATORY

Bloodland Cemetery

23d. LOCATION (City, town, or county)

Ft Leonard Wood Missouri

24. FUNERAL DIRECTOR

Moss-Williams Funeral Homes

25. DATE RECD. BY LOCAL REG.

4-12-61

26. REGISTRAR'S SIGNATURE

Emmanuel A. Williams

(Licensed Embalmer's Statement on Reverse Side)

VS MAY 10 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

Clarence E. Moore

Licensed Embalmer No.

4896

P. O. Address

Waynesville, N.C.

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.