

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-029966

STATE FILE NUMBER

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 26

AMENDED

FILED SEP 15 1961

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Odessa</u>	Length of stay in 1b <u>15 min</u>	c. CITY OR TOWN <u>Mayview</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>107 S. Sec.</u>		d. STREET ADDRESS (If outside, give location) <u>-----</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Lawrence</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1900</u>
9. AGE (last birthday) <u>61</u>		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) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Labor</u>	11. BIRTHPLACE (City and state or country) <u>Higginsville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Norris F. Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Manning</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Mansel, Divorced</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		17. INFORMANT Address <u>Paul Wilson, Odessa, Missouri</u>	
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>Ventricular Fibrillation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute Coronary</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>UNKNOWN</u> <u>UNKNOWN</u>
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
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. I attended the deceased from <u>9-9-61 9:30 AM</u> to <u>9-9-61 9:45 AM</u> and last saw him alive on <u>9-9-61 9:45 AM</u> Death occurred at <u>9:45 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Wayne Baydston MD</u>		22b. ADDRESS <u>107 S 2nd Odessa Mo.</u>	22c. DATE SIGNED <u>9-11-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-11-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Odessa, Lafayette, Mo.</u>
24. FUNERAL DIRECTOR <u>Ralph O. Jones, Odessa, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept. 12, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS SEP 15 1961

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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 O. Jones

Licensed Embalmer No. 4604

P. O. Address Odeson, M.

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.