

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

-61-033443

FILED SEP 26 1961

Registration District No. 170 Primary Registration District No. 3033 STATE FILE NUMBER Registrar's No. 161

V. S. 300
Rev. 1-57

0535

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>		
b. CITY OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Lebanon</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>432 Clark St.</u>		Length of stay in lb <u>5 yr.</u>	d. STREET ADDRESS <u>432 Clark St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Cecil</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/1946</u>	9. AGE (In years last birthday) <u>15</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Mexico, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>John Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Barcie Richardson</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Mrs. Barcie Wilson Lebanon, Mo.</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>Lobar Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Palsy</u>					life
DUE TO (c) <u>35.1x</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <u>7:45</u> Month <u>June</u> Day <u>1961</u> Year <u>1961</u> a.m. <u>P.</u> p.m.					
20d. INJURY OCCURRED WHILE AT <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>June 1961</u> to <u>death 9-18-61</u> and last saw <u>him</u> alive on <u>9-18-1961</u> Death occurred at <u>7:45 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. Fralich, MD</u> (Signature title)			22b. ADDRESS <u>Lebanon Mo.</u>		22c. DATE SIGNED <u>9-19-1961</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>9/21/1961</u>	<u>Jenkins Cemetery</u>		<u>Marion Home, Mo.</u>
24. FUNERAL DIRECTOR <u>Dorsey M. Howe</u> ADDRESS <u>Lebanon Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-20-1961</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Day</u>	

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1-0

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 *Dorsey M. Howe*

Licensed Embalmer No. *4222*
P. O. Address *Lebanon, N*

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.