

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

M. Wilson

-61-036376

STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 148

AMENDED

FILED OCT 30 1961

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Boonville		Length of stay in 1b 6 mon.	c. CITY OR TOWN La Plata, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 201 S. Church St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT IVISON SEARS			4. DATE OF DEATH Month Day Year October 22, 1961
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/18/81
9. AGE (last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drug	11. BIRTHPLACE (City and state or country) La Plata, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME James I. Sears	
13b. MOTHER'S MAIDEN NAME Malinda Thomas		14. NAME OF HUSBAND OR WIFE Evelyn Reesman	
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.	
17. INFORMANT Address Mrs H. I. Sears LaPlata, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE			INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CARCINOMA OF THE ESOPHAGUS			4 1/2 YEARS
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) EXTENSIVE METASTASIS TO THE CERVICAL LYMPH NODES			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 4/3/61 to 10/22/61 and last saw her/him alive on 10/20/61 Death occurred at 3:20 P.M. 10/22/61 on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M. Wilson, M.D.</i> (Degree or title)		22b. ADDRESS 329 MAIN, BOONVILLE, MISSOURI	22c. DATE SIGNED 10/23/61
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/24/61	23c. NAME OF CEMETERY OR CREMATORY LaPlata Cemetery	23d. LOCATION (City, town, or county) (State) LaPlata, Missouri
24. FUNERAL DIRECTOR Wilson Funeral Home ADDRESS LaPlata, Mo.		25. DATE RECD. BY LOCAL REG. 10/23/61	26. REGISTRAR'S SIGNATURE <i>D. Hooper</i>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Berry W. Shaker

Licensed Embalmer No. 3944

P. O. Address Boonville, Mo.

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.