

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-042008

STATE FILE NUMBER

AMENDED

Registration District No. 290
FILED NOV 21 1961

Primary Registration District No. _____

Registrar's No. 131

1. PLACE OF DEATH

a. COUNTY

Pulaski

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

Length of stay in 1b

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c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION General Hospital

Inside Limits

Yes ☒ No ☐

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

a. STATE Missouri COUNTY Pulaskic. CITY
OR TOWNDevils Elbow

Inside Limits

Yes ☐ No ☒d. STREET
ADDRESS

(If outside, give location)

Clint Traylor Court

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Robert

Middle

Eugene

Last

Wilson II4. DATE
OF DEATH

Month

Nov

Day

12

Year

1961

5. SEX

Male

6. COLOR OR RACE

White7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Sept 10 1961

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

2

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

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Pamona California

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Robert Eugene Wilson

13b. MOTHER'S MAIDEN NAME

Rhea Rae Cahill

14. NAME OF HUSBAND OR WIFE

None

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.

None

17. INFORMANT

Address

Robert Eugene Wilson Devils Elbow Mo18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Medullary fractureConditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Cerebral apoplexy

DUE TO (c)

Lobar PneumoniaINTERVAL BETWEEN
ONSET AND DEATHPART 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☐ Unknown19. 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 ☐
NOT 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 _____, to _____ and last saw him alive on _____

Death occurred at _____

_____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

Waynesville, Missouri

22c. DATE SIGNED

11-13-6123a. BURIAL, CREMATION,
REMOVAL (Specify)Removal

23b. DATE

11-13-61

23c. NAME OF CEMETERY OR CREMATORY

Rose Hill Cemetery

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

Whittier California

(State)

24. FUNERAL DIRECTOR

Moss - Williams Crocker Mo

ADDRESS

25. DATE RECD. BY LOCAL REG.

11-13-61

26. REGISTRAR'S SIGNATURE

Paula Mae Anderson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 29 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 Moore

Licensed Embalmer No.

4896

P. O. Address

Waynesville, 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.