

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003386

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 53

FILED FEB 14 1962

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY <u>St. Francois</u>			a. STATE <u>Missouri</u> COUNTY <u>Washington</u>		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Length of stay in lb <u>10 day</u>	c. CITY OR TOWN <u>Caledonia</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>Bonne Terre Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>general delivery</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSA LENORA TILLSON</u>			4. DATE OF DEATH Month Day Year <u>Feb. 2 1962</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 1864</u>	9. AGE (last birthday) <u>97</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>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Conrad Norwine</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Christopher</u>		14. NAME OF HUSBAND OR WIFE <u>William Tillson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Mrs. Minnie Stokes, Fredericktown Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Carcinoma of Colon (suspected)</u>					?
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. USE TO (b) <u>arteriosclerotic heart disease</u>					
DUE TO (c) <u>Generalized arteriosclerosis</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 checked="" 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 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>1-24-62</u> to <u>2-2-62</u> and last saw her alive on <u>2-2-62</u> . Death occurred at <u>12.10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. E. Carleton, M.D.</u>			22b. ADDRESS <u>Farmington Mo</u>		22c. DATE SIGNED <u>2-5-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>2-4-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Caledonia Mo.</u>	
24. FUNERAL DIRECTOR <u>and white</u> ADDRESS <u>White Funeral Home, Ironton Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Feb 5, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

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 Rachel White

Licensed Embalmer No. 3012

P. O. Address Trouton, 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.