

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013775

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 58

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 19 1962

1. PLACE OF DEATH a. COUNTY <p style="text-align: center; font-size: 18pt;">Saline</p>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <p style="text-align: center; font-size: 18pt;">Marshall</p>		Length of stay in 1b <p style="text-align: center; font-size: 18pt;">20 years</p>		c. CITY OR TOWN <p style="text-align: center; font-size: 18pt;">Marshall</p>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <p style="text-align: center; font-size: 18pt;">Fitzgibbon hospital</p>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <p style="text-align: center; font-size: 18pt;">1504 South Benton</p>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <p style="text-align: center; font-size: 18pt;">Edward Marion Wasson</p>			4. DATE OF DEATH Month <u>March</u> Day <u>16th</u> Year <u>1962</u>		
5. SEX <p style="text-align: center; font-size: 18pt;">Male</p>		6. COLOR OR RACE <p style="text-align: center; font-size: 18pt;">White</p>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH <p style="text-align: center; font-size: 18pt;">5-6-1902</p>		9. AGE (last birthday) <p style="text-align: center; font-size: 18pt;">59</p>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center; font-size: 18pt;">Laborer</p>		10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center; font-size: 18pt;">General</p>		11. BIRTHPLACE (City and state or country) <p style="text-align: center; font-size: 18pt;">Pettis County, Mo.</p>	
12. CITIZEN OF WHAT COUNTRY <p style="text-align: center; font-size: 18pt;">USA</p>		13a. FATHER'S NAME <p style="text-align: center; font-size: 18pt;">Tom Wasson</p>		13b. MOTHER'S MAIDEN NAME <p style="text-align: center; font-size: 18pt;">Mattie Disney</p>	
14. NAME OF HUSBAND OR WIFE <p style="text-align: center; font-size: 18pt;">-----</p>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <p style="text-align: center; font-size: 18pt;">Yes World war 2</p>		16. SOCIAL SECURITY NO. <p style="text-align: center; font-size: 18pt;">None</p>	
17. INFORMANT <u>740 West</u> Address <u>Vers St.</u>		18. FARRIS SHEPARD, MARSHALL, 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) <p style="text-align: center; font-size: 18pt;">Cerebral Vas accident</p>		DUE TO (b) <p style="text-align: center; font-size: 18pt;">Cerebral Vas thrombosis</p>		DUE TO (c) <p style="text-align: center; font-size: 18pt;">Arteriosclerotic Vas disease 10 yrs</p>	
INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center; font-size: 18pt;">24 hr</p>		INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center; font-size: 18pt;">24 hr</p>		INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center; font-size: 18pt;">10 yrs</p>	
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.) <p style="text-align: center; font-size: 18pt;">Mar 16 4 PM</p>	
20f. CITY, TOWN, OR LOCATION <p style="text-align: center; font-size: 18pt;">Marshall</p>		20g. COUNTY <p style="text-align: center; font-size: 18pt;">Mo</p>		20h. STATE <p style="text-align: center; font-size: 18pt;">Miss</p>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>2 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <p style="text-align: center; font-size: 18pt;">C. Campbell-Lewis</p>			22b. ADDRESS <p style="text-align: center; font-size: 18pt;">Marshall Mo</p>		22c. DATE SIGNED <p style="text-align: center; font-size: 18pt;">3-16-62</p>
23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center; font-size: 18pt;">Burial</p>		23b. DATE <p style="text-align: center; font-size: 18pt;">3-18-1962</p>	23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center; font-size: 18pt;">Mt. Olive cemetery</p>		23d. LOCATION (City, town, or county) (State) <p style="text-align: center; font-size: 18pt;">Saline County, Mo.</p>
24. FUNERAL DIRECTOR <p style="text-align: center; font-size: 18pt;">Cambell-Lewis. Marshall, Mo.</p>			25. DATE RECD. BY LOCAL REG. <p style="text-align: center; font-size: 18pt;">3-17-'62</p>		26. REGISTRAR'S SIGNATURE <p style="text-align: center; font-size: 18pt;">Cecil J. Reed</p>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

6975
20975

3
4 C
5 0
6
7 0
8 0
9332X
10
11
12 1-0
13 3-0

MAY 22 1962

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,

on ~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

R. W. Campbell Jr.

Licensed Embalmer No.

3469

P. O. Address

Marshall, 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.