

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-019888  
STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. \_\_\_\_\_ Registrar's No. 39

**FILED MAY 27 1963**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HOLT</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND City</u> Length of stay in 1b <u>55 YEARS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission): a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u> c. CITY OR TOWN <u>MOUND City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>NELL ABIGAIL WILSON</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>MAY 17, 1963</u>				
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/11/1879</u>	<b>9. AGE (last birthday)</b> <u>84</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR.</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MILLINER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MILLINERY</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>HOLT Co., Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>JOSEPH G. WILSON</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>BETIE MEEK</u>			<b>14. NAME OF HUSBAND OR WIFE</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> Address <u>HAZEL H. LEHMANN KINGSTON TENN RT. 3</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) NATURAL CAUSES (PROBABLE CAUSE)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_ DUE TO (c) \_\_\_\_\_

**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.**  
 Yes  No  Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT SUICIDE HOMICIDE</b> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____			
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office/bldg., etc.) _____	
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____	

**21. I attended the deceased from** No \_\_\_\_\_, to \_\_\_\_\_, and last saw her/him alive on No \_\_\_\_\_.

Death occurred at UNKNOWN \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Howard Colbin D.O. Coroner Holt Co. Oregon, Mo.</u>	<b>22b. ADDRESS</b> _____	<b>22c. DATE SIGNED</b> <u>5-22-63</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>5-22-1963</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Liberty</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Holt Co. Missouri</u>
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>JAMES H. CRAWFORD MOUND City, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>5-22-1963</u>	
<b>26. REGISTRAR'S SIGNATURE</b> <u>James Crawford</u>			

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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USE BLACK INK OR TYPEWRITER RIBBON

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**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 James H. Winford

Licensed Embalmer No. 4796

P. O. Address Thousand City, 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.