

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020601

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 167 Primary Registration District No. 4256 Registrar's No. 30

FILED JUN 14 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0510
2 0510
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4 0
5 7
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7 1
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94201
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12 86-0
13 4-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Johnson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holden		Length of stay in 1b 50 years	c. CITY OR TOWN Holden Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Smead Retirement Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5th & Main St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Addison Ulysses Wetherill			4. DATE OF DEATH Month Day Year June 7, 1963
5. SEX Male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1870
9. AGE (last birthday) 92		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) Real estate		10b. KIND OF BUSINESS OR INDUSTRY Housing	11. BIRTHPLACE (City and state or country) Ohio.
12. CITIZEN OF WHAT COUNTRY USA.		13a. FATHER'S NAME Edwin Henry Wetherill	
13b. MOTHER'S MAIDEN NAME Amanda		14. NAME OF HUSBAND OR WIFE deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no.		16. SOCIAL SECURITY NO. ---	17. INFORMANT Address Shawnee, Kan. Mrs. Ruth Joy 10825 W. 51 Ter.
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 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) Gen. Arteriosclerosis & Prostatism 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 Aug 1961 to June 1963 and last saw him alive on June 7, 1963 Death occurred at 5:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Kelly Rawlins M.D.		22b. ADDRESS Holden Mo	22c. DATE SIGNED 6/8/63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6-10-63	23c. NAME OF CEMETERY OR CREMATORY Holden Cemetery	23d. LOCATION (City, town, or county) Holden, Mo.
24. FUNERAL DIRECTOR ADDRESS E B CAST HOLDEN MO		25. DATE RECD. BY LOCAL REG. 5-10-63	26. REGISTRAR'S SIGNATURE Bernice Ross

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF OHIO

OCT 15 1963

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

STATE OF OHIO
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
COLUMBUS, OHIO