

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023051

STATE FILE NUMBER

Registration District No. **378** Primary Registration District No. **6285** Registrar's No. **24**

FILED MAY 27 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 **1140**
2 **1070**
3
4 **1**
5 **1**
6
7 **0**
8 **0**
9 **X**
10
11 **114**
12 **91-0**
13 **2-0**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

1. PLACE OF DEATH a. COUNTY Wright		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mtn. Grove Township		c. CITY OR TOWN Cabeol	
Length of stay in 1b Accident		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital; give location) HOSPITAL OR INSTITUTION Rwy. 60-3 miles west-Mtn Grove		d. STREET ADDRESS (If outside, give location) Route 2	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH WILSON			4. DATE OF DEATH Month April Day 24 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1920
9. AGE (last birthday) 42 Years		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country). Buchanan County, Mo
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Hugh Aiken	
13b. MOTHER'S MAIDEN NAME Edith Sloan		14. NAME OF HUSBAND OR WIFE Lowell Wilson	
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 Lowell Wilson - Cabeol, Missouri		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Neck Crushed Neck			INTERVAL BETWEEN ONSET AND DEATH 4-24-63 4-24-63
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) Autonotet Amnesia			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 checked="" 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.) Autonotet Amnesia	
20c. TIME OF INJURY Hour 9:45 p.m. Month, Day, Year 4-24-63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Dr. assistants and last saw her/him alive on Death occurred at 5:45 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter Jones MD		22b. ADDRESS Walter Jones MD	
22c. DATE SIGNED 4-29-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/1963	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION (City, town, or county) (State) Mountain Grove, Missouri	
24. FUNERAL DIRECTOR Barber Funeral Home - Mtn. Grove, Mo		25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE Barber Funeral Home - Mtn. Grove, Mo	

2954

876

APR 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 Barb Davis Student Embalmer No. 678

working under my personal supervision.

Student Bob Davis
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No. 5161

P. O. Address Mr. Boone, MD

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.

[Handwritten scribbles]