

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035718

STATE FILE NUMBER

FILED OCT 21 1958 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 489

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wayne</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		c. CITY OR TOWN <u>Patterson (Rural)</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>South East Mo.</u>		Length of stay in lb <u>4 Weeks</u>	
3. NAME OF DECEASED (Type or print) <u>William C. Sheets</u>		4. DATE OF DEATH <u>Oct. 8 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>Wayne, Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Buel Sheets</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Haggatt</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>487-30-4106</u>	
17. INFORMANT <u>R. L. Sheets</u>		Address <u>Cape Girardeau Mo</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) <u>UREMIA</u> DUE TO (b) <u>Arteriosclerosis</u> and <u>Cardiac failure</u> 4500H PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cancer of prostate metastatic--Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
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 <u>o.m.</u> Month, Day, Year <u>p.m.</u>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>May 1955</u> to <u>Oct 8, 1958</u> and last saw him alive on <u>Oct 8, 1958</u> Death occurred at <u>6:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John Cronner M.D.</u>		22b. ADDRESS <u>Cape Girardeau, Missouri</u>	
22c. DATE SIGNED <u>Oct 10, 1958</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-10-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Liberty</u>		23d. LOCATION (City, town, or county) (State) <u>Wayne Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>William Border</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 18, 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Homer Cooper</u>			

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc., must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part 1 must be causally related.