WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Jackson

Township or Village or City Independence (NO. 916 N. Main St.; 1 Ward)

Registration District No. 398 File No. 26188

Primary Registration District No. 3019 Registered No. 191

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Nora Francis Wilson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Aug 23rd (Month) (Day) 1912 (Year)

AGE 61 yrs. 0 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 9-0-9

BIRTHPLACE (City or town, State or foreign country) Pleasant Hill Mo

PARENTS

NAME OF FATHER Chas R Wilmott

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky

MAIDEN NAME OF MOTHER Sarah J Parker

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna B. Cole

(ADDRESS) Biggs, Okla

Filed Aug 24 1912 C. E. Krimminger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 23 (Month) (Day) 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 12, 1912, to Aug 23, 1912, that I last saw her alive on Aug. 23, 1912, and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

130

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Coma

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) C. E. Krimminger M. D.

Aug 23 1912 (Address) Indep. Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Pleasant Hill

DATE OF BURIAL 8-26 1912

UNDERTAKER Earl Parker

ADDRESS P. Hill Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St., _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.