

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 Pettis

Township _____

or

Village _____

or

City Sedalia

(NO. _____)

Registration District No. 668

File No. _____

5662

Primary Registration District No. 3032Registered No. 43

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

FULL NAME John Miller Wilson

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(If write the word)Married

DATE OF BIRTH

Mar 19, 1882
(Month) (Day) (Year)

AGE

91 yrs. 10 mos. 27 ds.If LESS than
1 day, ____ hrs.
or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

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

BIRTHPLACE

(City or town, State or foreign country)

Pa

PARENTS

NAME OF FATHER

Miller Wilson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ireland

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

11

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Wilson

(ADDRESS)

Osage City, Mo.

Filed

Feb 16, 1914H. B. Long

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Feb, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 7, 1914, to Feb 15, 1914, that I last saw him alive on Feb 13, 1914, and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH was as follows:

108 Pneumonia (Polar)
12A Mitral Insufficiency

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Mitral Insufficiency
(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. B. Starnes, M. D.Feb 15, 1914 (Address) Sedalia, 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

Black water, Mo.

DATE OF BURIAL

Feb 17, 1914

UNDERTAKER

Sedalia Mortuary Co.

ADDRESS

Sedalia, Mo.

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

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	DATE OF DEATH	
	SINGLE MARRIED WIDOWED OR DIVORCED (If not the word)		
DATE OF BIRTH			
	(Month) _____ (Day) _____ (Year) _____		
AGE			
	yr. _____ mos. _____ ds. _____		
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)			

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)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____

(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

ADDRESS

UNDERTAKER

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191

REGISTRAR