

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

16979

PLACE OF DEATH
County Pulaski
Township Piney
or
Village _____
or
City _____

Registration District No. 214 File No. _____
Primary Registration District No. 5843 Registered No. _____

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

FULL NAME Wm Luther Wilson (NO. _____ St. _____ Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH March 3, 1914
(Month) (Day) (Year)

AGE 0 yrs. 2 mos. 15 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) 0

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

PARENTS
NAME OF FATHER Claude Wilson
BIRTHPLACE OF FATHER Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Lilly Belle Warren
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claude Wilson

(ADDRESS) Big Piney, Mo.

Filed 5-21-1914 C. Mallett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 18, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 5-17, 1914, to 5-18, 1914, that I last saw him alive on 5-18, 1914, and that death occurred, on the date stated above, at P. m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
107A

(Duration) 0 yrs. 2 mos. 4 ds.

Contributory 0
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. Mallett M. D.
5-21-1914 (Address) Blacksburg, 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 Watts Cem. DATE OF BURIAL 5-18, 1914

UNDERTAKER Lara Warren ADDRESS Big Piney Mo.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

(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

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH

(Month)	(Day)	(Year)
IF LESS than 1 day, ... hrs. or ... min.?		
... yrs. 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)

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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month), 191..... (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.

(Address)

....., 191.....

*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. 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

UNDERTAKER

ADDRESS

....., 191.....

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.