

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH
County Pelto
Township _____
or _____
Village _____
or _____
City Sedalia (NO. 7th & Montean St. 4 Ward)

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

Registration District No. 668 File No. 20172
Primary Registration District No. 3032 Registered No. 140

FULL NAME Burwell Goode Wilkerson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE widowed
MARRIED
WIDOWED
OR DIVORCED
(If not the word)

DATE OF BIRTH May - 11 - 1836
(Month) (Day) (Year)

AGE 78 yrs. 1 mos. 1 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER Charles Neal Wilkerson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Elizabeth Goode
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gro. R. Wilkerson
(ADDRESS) "Sedalia Missouri"

Filed June 15, 1914 H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 12, 1914
(Day) (Month) (Year)

I HEREBY CERTIFY that I attended deceased from June 9, 1914 to June 12, 1914, that I last saw him alive on June 12, 1914, and that death occurred, on the date stated above, at 10 P.m. The CAUSE OF DEATH was as follows:
Apoplexy

Contributory (SECONDARY) neuropathic (integrated)
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) M. B. Shy M. D.
6-13, 1914 (Address) St. Louis

*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 Crown Hill Cemetery DATE OF BURIAL June 15, 1914

UNDERTAKER M. Laughlin Bros ADDRESS Sedalia 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 (If file the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (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) _____

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 _____

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REGISTRAR _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____ (Day) _____ (Year) 191 _____

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) _____

(Address) _____ M. D. _____

*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 _____ 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

REGISTRAR _____

191 _____