

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

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

County Frank  
Township Green  
or Camell P.O.  
Village Camell P.O.  
or  
City (NO. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

Registration District No. 1057

File No. 35103

Primary Registration District No. 6214

Registered No. 3

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

FULL NAME Samuel Augustus Wilson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White Married  
~~SINGLE~~  
~~MARRIED~~  
~~WIDOWED~~  
~~OR DIVORCED~~  
(If single, the word)

DATE OF DEATH Nov-10<sup>th</sup>

(Month) (Day) (Year)

DATE OF BIRTH Oct 13, 1841  
(Month) (Day) (Year)

AGE 48 yrs. 00 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) Rodney New Jersey  
NAME OF FATHER Loell Nelson

BIRTHPLACE OF FATHER (City or town, State or foreign country) New Jersey  
MAIDEN NAME OF MOTHER Mary Veil  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Blanchfield New Jersey

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr & Mrs Albert Nelson  
(ADDRESS) Camell Mo R.D.

Filed Nov 12 1919 T. M. Cox  
REGISTRAR

I HEREBY CERTIFY, that I attended deceased from Nov 1, 1919, to Nov 10, 1919, that I last saw him alive on Nov 8, 1919, and that death occurred, on the date stated above, at 7<sup>12</sup> p.m.  
The CAUSE OF DEATH\* was as follows:

99A  
150 acute nephritis  
150 19 (Duration) yrs. 3 mos. 3 ds.  
Contributory Embolism with amputation of leg (SECONDARY) (Duration) yrs. 7 mos. 7 ds.  
(Signed) Egbert Crowson M. D.  
Nov 11, 1919 (Address) Parnell 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 Oxford DATE OF BURIAL Nov 12 1919  
UNDERTAKER Roof & Laffavor ADDRESS Parnell Mo

# PLACE OF DEATH

# MISSOURI STATE BOARD OF BUREAU OF VITAL STATIST CERTIFICATE OF DEATH

# Revised United States Standard Certificate of Death

"Typhoid pneumonia"; *Lobar pneumonia*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*; *meninges*; *peritoneum*, etc.,

County \_\_\_\_\_ Township \_\_\_\_\_ File No. \_\_\_\_\_  
or \_\_\_\_\_ Village \_\_\_\_\_ Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (NO) \_\_\_\_\_ St. \_\_\_\_\_ Ward) \_\_\_\_\_  
(If de  
hospital  
give it  
of street

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

|               |                                        |                                                                   |
|---------------|----------------------------------------|-------------------------------------------------------------------|
| SEX           | COLOR OR RACE                          | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(If wife the word) |
| DATE OF BIRTH | (Month) _____ (Day) _____ (Year) _____ |                                                                   |
| AGE           | _____ yrs. _____ mos. _____ ds.        | IF LESS than<br>1 day _____ hrs.<br>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<br>(City or town, State or foreign country) |  |
| MAIDEN NAME OF MOTHER                                            |  |
| BIRTHPLACE OF MOTHER<br>(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) \_\_\_\_\_

I HEREBY CERTIFY, that I attended de

\_\_\_\_\_, 191\_\_\_\_, to

that I last saw h\_\_\_\_\_ alive on

and that death occurred, on the date stated above, at \_\_\_\_\_

The CAUSE OF DEATH was as follows:

Contributory

(SECONDARY)

(Signed)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

(Address)

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAMENINGES, peritoneum, etc.,

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BU

UNDERTAKER

ADDRESS