

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

Do not use this space.

30433

1. PLACE OF DEATH

County Jackson Registration District No. 308 File No. _____
 Township Paris Ordinary Registration District No. 7 Registered No. 3540
 City Paris (No. General Hospital) St. _____ Ward _____

2. FULL NAME

Joe Wilson
 (a) Residence, No. 2809 Gilliam St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 20 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 9 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman for K O Gas Co
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer Gas Co

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Albia Iowa

10. NAME OF FATHER Gilbert Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Luella Kuleman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Albia Iowa

14. INFORMANT Deputy Coroner
 (Address) K. B. Bro

15. FILED 10-18-27 M. M. Crane REGISTRAR
asse

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 16 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Femoral - Lacerations
173 177
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Deputy Coroner, M. D.
 10/16 ID (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mt. Washington Oct 19 1927

20. UNDERTAKER ADDRESS

A. Secheta City

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.

