FEB 20 1928

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

Do not use this space. 324

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No.
Township — Primary Registration District No. 1001 — Registered No. 137
City St Joseph (No. 618 So. 22nd St. Ward)

2. FULL NAME Mary Wilkerson
(a) Residence. No. 618 So 22nd St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Dan Wilkerson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 25 1855

7. AGE: Years 73 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: none
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9. BIRTHPLACE (CITY OR TOWN): Sparta
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Jesse Morton
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Va.
(STATE OR COUNTRY): Va.
12. MAIDEN NAME OF MOTHER: Mahala White
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ky.
(STATE OR COUNTRY): Ky.

14. INFORMANT: Mary Wilkerson
(Address) 618 So 22nd St

15. FILED FEB 3 1928 19 John G. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 31 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1928, to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 12:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 74 A
(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? Need No
WHAT TEST CONFIRMED DIAGNOSIS? Need Historical of attack
(Signed) J. W. Mays Coroner, M. D.
, 19 (Address) St Joseph Mo

*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: Ashland Cemetery — DATE OF BURIAL: Feb 3 1928

20. UNDERTAKER: J. F. Ramsey Funeral Service — ADDRESS: 9½ Olive

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

72-2-6

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Buchanan Registration District No.: 85 File No.:
Township: Primary Registration District No.: 1001 Registered No.: 137
City: St Joe (No.: St. Ward)

2. FULL NAME: Mary Wilkerson

(a) Residence. No.: (Usual place of abode) St., Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 25-1833

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	72	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

INFORMANT
(Address)

15. FILED 3-9 1928 John G Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
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IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
, 19 (Address)

*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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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