

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

Do not use this space.

36613

1. PLACE OF DEATH

County Cedar
Township Linn
City Stockton, Mo.

Registration District No. 163
Primary Registration District No. 231

File No. _____
Registered No. 63
St. _____ Ward _____

2. FULL NAME

Caroline Matilda Wilson

(a) Residence. No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 W. B. Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 9 - 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 8 6 or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Boone Co.
(STATE OR COUNTRY) Arkansas

10. NAME OF FATHER Frank White

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

12. MAIDEN NAME OF MOTHER Mahalia Matlock

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Arkansas

14. INFORMANT W. B. Wilson
(Address) Stockton, Mo. #11.

15. FILED Dec. 29 E. S. Smith
Mary Boykin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1929

17. I HEREBY CERTIFY, That I attended deceased from 12
Monday, 1929, to Nov 15, 1929,
that I last saw him alive on Nov 14, 1929, and that
death occurred, on the date stated above, at 2:45 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Jaundice of the
liver
48
46 (duration) _____ yrs. _____ mos. _____ da.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS: _____

(Signed) Dr. H. H. Higgins, 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

Bald Mound Cem - DATE OF BURIAL Nov 16 1929

20. UNDERTAKER

Claudia Ward ADDRESS Greenfield
Mo.

USE 1929
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.
WHITE PLAINLY, WITH OUTLINED MARKINGS

