

SEP 26 1930

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

Do not use this space.
J. J. Goff

1. PLACE OF DEATH

County Camden Registration District No. 601
Township Maple Primary Registration District No. 4388
City Caruthersville (No. _____) St. _____ Ward _____

File No. _____
Registered No. 114

2. FULL NAME

Freddie 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-2-1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
28 5 11 23

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

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

10. NAME OF FATHER A Wilson

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

12. MAIDEN NAME OF MOTHER Emma Higgins

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

14. INFORMANT F. Wilson
(Address) Caruthersville

15. FILED Sept 10 1930 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-13 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on 6-20-30, and that death occurred, on the date stated above, at 6-15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

T.B.
Pulmonary
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 31
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) George J. Collins, M.D.

Aug 13 1930 (Address) Caruthersville 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 Maple Cemetery DATE OF BURIAL 8-14-30

20. UNDERTAKER J. H. Smith ADDRESS Caruthersville Mo

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.

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