

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAY 20 1932

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

Do not use this space.

61

1. PLACE OF DEATH  
 County Andrew Registration District No. 912  
 Township \_\_\_\_\_ Primary Registration District No. 4550  
 City Vandalia (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Urban Wilson  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 1, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
72 11 30

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo 1

FATHER  
 13. NAME William F Wilson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind 2

MOTHER  
 15. MAIDEN NAME Mary Harris  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N York

17. INFORMANT (ADDRESS) Hyman Wilson

18. BURIAL, CREMATION, OR REMOVAL PLACE Days Creek DATE Jan 31 1932

19. UNDERTAKER (ADDRESS) W. W. Water

20. FILED 1/31 Dr. Carrie F. Wittback Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30 1932

22. I HEREBY CERTIFY, That I attended deceased from Jan 29 1932 to Jan 30 1932.  
 I last saw him alive on Jan 29 1932. Death is said to have occurred on the date stated above, at 2 P. M.  
 The principal cause of death and related causes of importance were as follows:  
apoplexy  
82A 82A  
 Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify A. H. Bland, M. D.  
 (Signed) \_\_\_\_\_ (Address) Vandalia

100

100