

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

Do not use this space.

JUL 19 1935

19202

1. PLACE OF DEATH

County *Chariton* Registration District No. *172*
Township *Mendon* Primary Registration District No. *5238*
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. *6*

2. FULL NAME

(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.

John M. Wilson

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) *Ida Wilson*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 28-1864*
7. AGE YEARS *71* MONTHS *0* DAYS *14* If LESS than 1 day, _____ hrs. or _____ min.

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) *Carroll Co. Mo.*

FATHER 13. NAME *John Wilson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Suprona Applegate*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT *L.arence Wilson* (ADDRESS) *Triplet Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Ms. Cullough* DATE *6/13/35*

19. UNDERTAKER *S. L. Husband* (ADDRESS) *Mendon Mo*

20. FILED *6/17 19 35* *widowed* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 11 1935*

22. I HEREBY CERTIFY that I attended deceased from *May 15 1935* to *June 11 1935*
I last saw him alive on *June 7 1935* Death is said to have occurred on the date stated above, at *11 a m.*

The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset _____

Other contributory causes of importance: *None*

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 _____
(Signed) *[Signature]* M. D.
(Address) *[Address]*

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.

