

AUG 27 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Madaway*Registration District No. *620*File No. *27948*

Township

Primary Registration District No. *3031*Registered No. *68*City *Maryville*No. *St. Francis Hospital*

St. _____ Ward) _____

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

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

10-24-1936

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

*7**8**10*

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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)

Humansville Mo.

13. NAME

David N. Wilson

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

St. Clair Co. Mo.

15. MAIDEN NAME

Catherine Chrt.

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

Walbach Mo.

17. INFORMANT (ADDRESS)

David N. Wilson Rock Port Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Hunter Cem.* DATE *7-6-37*

19. UNDERTAKER (ADDRESS)

Trif Batcher Rock Port Mo.

20. FILED

7-6 1937 Mame E. Clardy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-4-37*22. I HEREBY CERTIFY, That I attended deceased from *7-4-37*, 19*37*, to *7/4/37*, 19*37*.I last saw him alive on *7-4-37*, 19*37*. Death is saidto have occurred on the date stated above, at *2:40 p.m.*

The principal cause of death and related causes of importance were as follows:

Date of onset

Broncho. Pneumonia

Other contributory causes of importance:

Secondary Measles

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? *no*23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19*37*

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) *M. A. Tullman*, M. D.(Address) *Fairfax 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.

