

REC'D FEB 23 1939

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

2122
Do not use this space.

1. PLACE OF DEATH

(a) County Callao Registration District No. 247
(b) Township Wilson Primary Registration District No. 5343
(c) City Long Lane (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

425 Nancy Jane Wilson
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Wilson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 8, 1855
7. AGE YEARS 83 MONTHS 4 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-4 1939
22. I HEREBY CERTIFY, That I attended deceased from 1-1, 1939 to 1-4, 1939. I last saw him alive on 1-1, 1939. Death is said to have occurred on the date stated above, at 4 m. The principal cause of death and related causes of importance were as follows:

Pneumonia Lobar Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) Laclede Co. Mo. (STATE OR COUNTRY) _____

Other contributory causes of importance: Flu
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

FATHER 13. NAME Andrew Hughbert 14. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME Mary Moore 16. BIRTHPLACE (CITY OR TOWN) Jenn (STATE OR COUNTRY) _____

17. INFORMANT E. M. Wilson (ADDRESS) Long Lane Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Woods DATE 1-6 39

19. FUNERAL DIRECTOR (NAME) J. B. Jones (ADDRESS) 1314 Buffalo St

20. FILED 2-10 39 J. Falbot Local Registrar.

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? No If so, specify _____ (Signed) J. W. Runday M. D. Courway (Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be extremely supplied.

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RECEIVED

District Health Officer No. 70

District File Number 7-39-30

Date Filed 2-13-29

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.