

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

21110
Do not use this space.

1. PLACE OF DEATH **10 1939**
 (a) County Jackson Registration District No. 399
 (b) Township Franklin Primary Registration District No. 1002
 (c) City H.C. (d) Street No. General Hospital Registered No. 2578 St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Lyle Wilson
 (a) Residence, No. 409 N 11th St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ma 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
approx 43 X X

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Salesman
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 16 3/4

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. 0

FATHER 13. NAME unknown 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME unknown 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) B. M. Fitzgerald
Dominion Health Hotel

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Greenland Bur 6-9-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. H. Hageman & Sons
120 E. Me

20. FILED June 8 1939 M. M. Brown
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-6-39 19

22. I HEREBY CERTIFY that I attended deceased from 10:20 a.m. 19
 I last saw him alive on 6-6-39 Death is said to have occurred on the date stated above, at 10:20 a.m.
 The principal cause of death and related causes of importance were as follows:
Septicemia
 Date of onset

Other contributory causes of importance:

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide. Date of injury 6-6-39
 Where did injury occur? K.C., Mo. (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Do not know
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify

(Signed) Walter M. Butler M. D.
 (Address) San Diego, N.P. Mo

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.

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.