

REC'D SEP 12 1939

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

29122
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001 Registered No. 602
 (c) City SPRINGFIELD (d) Street No. St. John's Hospital 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 425 E. CNICHELMA WILSON St. MO Montreal Mo
EMONTREAL (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) SINGLE

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-2 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 7-31, 1938, to 8-2, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 2 1929

I last saw her alive on 8-2, 1939 Death is said to have occurred on the date stated above, at 5:30 A. m.

7. AGE YEARS 19 MONTHS 10 DAYS 0 If LESS than 1 day,hra. ormin.

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. In home
 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

1) Septicemia, streptococci
59
 Date of onset 7-31

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MONTREAL MO

Other contributory causes of importance:
1) Tuberculosis, chronic
2) Diabetes mellitus
Diabetes mellitus

FATHER 13. NAME TIBLOW-WILSON

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

MOTHER 15. MAIDEN NAME ESTA-JEFFRIES

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

Name of operation _____ Date of _____
 What test confirmed diagnosis _____ Was there an autopsy No

17. INFORMANT (ADDRESS) Esta Wilson
Montreal Mo

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.

18. BURIAL, CREMATION, OR REMOVAL OF ~~Body~~ MO
 PLACE FREEDOM DATE Aug 3 1939

Manner of injury _____
 Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS) Bandson Woodley
Camden Mo

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Medical Staff M. D.

20. FILED Aug 7 1939 Chas. Berglund
 Local Registrar

(Address) Springfield Mo

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,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29122
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township Springfield Primary Registration District No. 2001 Registered No. 602
(c) City Springfield (d) Street No. _____
(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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Emmie Elma Wilson
(a) Residence, No. _____ 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (circle the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 2 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
9 10 -

OCCUPATION
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.
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)

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

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct 2 1939 Chas A George RED
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-2-1939

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Date of onset

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 _____

(Signed) J. H. Kaufmann, M. D.

(Address) 1800 West 1st St, Springfield, Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

REGISTRATION IS VERY IMPORTANT. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

S-29122