

No. 2
1-10-39
1-17-39
1-21-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3109
Registrar's No. 5

Registration District No. 566

Primary Registration District No. 5762

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: 2
(a) County Mississippi
(b) City or town Rural-Tywappity township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2 1/2 Mi. N.E. of Charleston, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community About 6 years
years, months or days)

8. (a) PRINT FULL NAME Maude Wilkins 425
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race Color 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Willis Wilkins 6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased March 14 1895
(Month) (Day) (Year)

8. AGE: Years 44 Months 1 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Oxford, Miss.
(City, town, or county) (State or foreign country)

10. Usual occupation House keeper

11. Industry or business XXX

12. Name J.D. Ferrell

13. Birthplace XXX Miss. 9
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Andy Ferrell

(b) Address Route # 2, Charleston, Mo.

17. (a) Burial (b) Date thereof 1-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove-Charleston

18. (a) Signature of funeral director Paul B. Baw

(b) Address Charleston Mo

19. (a) 1-19-40 (b) J. D. Ferrell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Mississippi
-Rural-
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 2 1/2 Mi. N.E. of Charleston
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 17th.
year 1940 hour 8 minute 30 PM.

21. I hereby certify that I attended the deceased from Jan 17
1939, to Jan 17, 1939,
that I last saw her alive on Jan 17, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy cerebellar Duration 1 day

Due to Hypertension

Due to g. 2 u

Other conditions. (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations. _____
Of autopsy. _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Paul B. Baw (M. D. or other) 1/18/40
Address Charleston Mo Date signed 1/18/40

RECEIVED

District Health Officer No. 2,

District File Number

Date Filed

240-394

2/12/40

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.