

11481

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

11481

Registration District No. 44-9Primary Registration District No. 5613

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON RURAL SPRING HOLLOW Mo. State Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7
(Specify whetherIn this community 23 YRS.
years, months or days)3. (a) PRINT FULL NAME MARY C. WILBUR 416

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOW6. (b) Name of husband or wife ABRAHAM WILBUR 6. (c) Age of husband or wife if7. Birth date of deceased APR 4 1856
(Month) (Day) (Year)8. AGE: Years 83 Months 10 Days 27 If less than one day
hr. min.9. Birthplace WARREN CO IOWA
(City, town, or county) (State or foreign country)10. Usual occupation H W K

11. Industry or business _____

MOTHER FATHER { 12. Name ABEL DALBEY13. Birthplace IOWA
(City, town, or county) (State or foreign country)14. Maiden name HANNAH FETTERS15. Birthplace IOWA
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Joe Walker(b) Address BRICE RT Lebanon Mo17. (a) Burial (b) Date thereof Mar 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Polk Cemetery18. (a) Signature of funeral director Polk(b) Address Lebanon Mo 41619. (a) 3-2-1948 (b) J. H. McCoub
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) City or town BRICE RT. Lebanon Mo. State Mo (b) County Laclede
(If outside city or town limits, write "RURAL")(d) Street No. BRICE RT.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 1
year 1940 hour 7 minute 20 P. M.21. I hereby certify that I attended the deceased from 2-13
1940, to 2-25, 1940;that I last saw her alive on 2-25, 1940;

and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 4 days
Arterio Sclerosis (Heart)Due to Arterio-Sclerotic (Heart) Disease

Due to _____

Other conditions Arterio Sclerosis
(Include pregnancy within 3 months of death)Major findings: ASD
Of operations _____

Of autopsy _____

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 Henry Wachuga (M. D. or other) (M.D.)Address Lebanon Mo Date signed 3-2-40

PHYSICIAN

Underline the cause to which death should be charged statistically

(Licensed Embalmer's Statement on Reverse Side)

FORM 5-17-38
REV. 5-17-38
I 19351

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED

District Health Officer No. 7,

District File Number 4-40-641

Date Filed 4-12-40

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 W. Babmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

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.