

No. 2  
11-10-39  
-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14542

FD MAY 9 1940

State File No. \_\_\_\_\_

Registration District No. 135

Primary Registration District No. 3010

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Carrollton  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

(c) City or town Carrollton  
(If outside city or town limits, write "RURAL")

(d) Street No. 16 West 1st St  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Joseph Edward Wilson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3<sup>rd</sup>  
year 1940 hour 12<sup>th</sup> minute \_\_\_\_\_ M.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah S Wilson

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 12 15 1866  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 4 1939 to May 3 1940  
that I last saw him alive on May 3 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 6 Days 15  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Urticaria Schori  
Cerebral Softening

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Wakanda Mo.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Edward Wilson

13. Birthplace Kennett Ky  
(City, town, or county) (State or foreign country)

14. Maiden name Angeline Kilgus

15. Birthplace Ohio  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underlines the cause to which death should be charged statistically.

16. (a) Informant Clyde Wilson

(b) Address Carrollton Mo

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? \_\_\_\_\_

17. (a) Buried (b) Date thereof 5-5-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Adkins Cem

130

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Willis Marshall

(b) Address Carrollton Mo

19. (a) 5-4-1940 (b) Pete Haskins  
(Date received local registrar) (Registrar's signature)

23. Signature W M Benson (M. D. or other) \_\_\_\_\_

Address Carrollton Mo Date signed 5/4/40

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

7  
3

APR 29 1953

**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 me

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

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton 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.**