

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.

FILED MAY 1 1940

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

15161
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper 2 Registration District No. 411

(b) Township Jasper Primary Registration District No. 2002 Registered No. St. John's Hospital

(c) City Joplin (d) Street No. 2203 Commercial (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 Mary Sheron Wilson

(a) Residence, No. 425 (Usual place of abode, if no street address, write county or city) St. Mayville, Ark. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-12-1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

0 10 mo 2

OCCUPATION

8. Trade, profession, or particular kind of work done, as a lawyer, 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) Mayville, Ark.

FATHER

13. NAME Rollin Wilson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hastings, Neb.

MOTHER

15. MAIDEN NAME Viola Brumager

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keokuk, Iowa

17. INFORMANT (ADDRESS) Rollin Wilson
Mayville, Ark.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ark. DATE 4-22-40

19. FUNERAL DIRECTOR (ADDRESS) Tom Clarke
Mayville, Ark.

20. FILED 4-29-40 Ed B. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/20 1940

22. I HEREBY CERTIFY, That I attended deceased from 4/6, 1940, to 4/20, 1940.

I last saw him alive on 4/10, 1940. Death is said to have occurred on the date stated above, at 11:50 a.m.

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

Old embolus - March 1, 1940

Pulm Abscess

Other contributory causes of importance:

1 Sunday Dinner - March 1, 1940

Name of operation _____ Date of _____

What test confirmed diagnosis? Blow cut 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? No

If so, specify _____

(Signed) W. H. H. H. _____, M. D.

(Address) Joplin

373 (Licensed Embalmer's Statement on Reverse Side)

40-5-66

72.02

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 with the above constitutes grounds for revocation of license.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-161

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Joplin
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mary Sharon Wilson

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 2 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

DECLARATION OF PHYSICIAN

20. DATE OF DEATH: Month 4 day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Ends Carditis
Pulmonary abscess
Due to _____
Cause unknown
Due to _____

Other conditions secondary anemia
(include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

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 E. Elrod Moody (M. D. or other) _____

Address Joplin Mo Date signed _____

SUPPLEMENTARY

