

REC'D MAY 8 1940

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

16293
Do not use this space.

1. PLACE OF DEATH
 (a) County Stoddard Registration District No. 836
 (b) Township Elk Primary Registration District No. 6102
 (c) City Atkins, Mo. (d) Street No. _____ 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 23 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME U20 Ethel Wills
 (a) Residence, No. R.F.D. # 2, Walden Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 27, 1916
 7. AGE YEARS 23 MONTHS 8 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home girl
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 21, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1939, to April 20, 1940
 I last saw her alive on Mar 1, 1940. Death is said to have occurred on the date stated above, at 6 P. m.
 The principal cause of death and related causes of importance were as follows:
Degeneration of abdominal tissue, due to surgical operations in Jan. 1938 at St. Francis Hosp.
 Date of onset N.K.
 Other contributory causes of importance: unknown
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? No
 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) Edward J. Ford, M. D.
 (Address) Parma Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 FATHER 13. NAME Henry Wills
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bollinger County Mo.
 MOTHER 15. MAIDEN NAME Orby Lee
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bollinger County Mo.
 17. INFORMANT (ADDRESS) Henry Wills #2, Walden, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Berme, Mo. DATE Apr. 28, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dunham Funeral Home Berme, Mo.
 20. FILED Apr 25, 1940 Laura Hopkins Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

WHITE PRINTING, WITH UNFADING INK---THIS IS 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.

1 X16605

2002

RECEIVED

District Health Officer No. 2,

District File Number 540-99

Date filed 5/7/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16290**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **836**

Primary Registration District No. **6100**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Stoddard**

(b) City or town **etc.**

(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 _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **Ethel Wills**

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 **8**

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 **23** Months **8** Days **24** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (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)

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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **21** year _____ 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 **Degeneration abdominal tissue due to surgical shock**

Due to **operation in Jan 1938 at St Francis Hosp**

Due to **Unknown, + the parents could not remember**

Other conditions **well known to the me** (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **20 W over**

Duration _____

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)

(a) Means of injury _____

23. Signature **Edward Ford** (M. D. or other) _____

Address **Jama** Date signed _____

SUPPLEMENTARY

Apparently not malignant
Wound just would not heal -