

JUN 18 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

18451

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

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 476

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Burge Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Charles Roland Wilson <sup>425</sup>

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased May 27 1940  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name Charles Wilson

13. Birthplace Dade County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Violet Abner

15. Birthplace Dade County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Charles Wilson - Father

(b) Address Everton, Mo

17. (a) Removal (b) Date thereof May 29 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Family Disposal

18. (a) Signature of funeral director Charles Wilson

(b) Address Dade Co, Missouri

19. (a) May 29 1940 (b) W. C. Haudley MD  
(Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar  
(c) City or town Everton  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28  
year 1940 hour 10 PM minute 0 M.

21. I hereby certify that I attended the deceased from 5-27 1940 to 5-28 1940  
that I last saw him alive on 5-28-40 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Trauma injury  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 16 1/2

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
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?  
9814  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Lee B. Bisset (M. D. or other) MD  
Address Springfield Mo Date signed 5-29-40

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

MOTHER FATHER

**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.**