

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18880**

Registration District No. **477**

Primary Registration District No. **4286**

Registrar's No. **22**

1. PLACE OF DEATH:
 (a) County **Lewis**
 (b) City or town **Canon Mo**
 (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 **2**
 In this community **50 years**
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME **Emilia Dewilder's**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **Widow**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Dec 10 1886**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 5 1 hr. _____ min.

9. Birthplace **St. Louis Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____
 12. Name **William Hamley**
 13. Birthplace **Wendenburg Germany**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Catherine Hamley**
 15. Birthplace **New Orleans Louisiana**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Catherine Hamley**
 (b) Address **Canon Mo**

17. (a) **Burial** (b) Date thereof **5 13 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Canon Mo 5-13-40**

18. (a) Signature of funeral director **H. S. Kelly**
 (b) Address **Canon Mo**

19. (a) **5-13-1940** (b) **H. W. Harris M.D.**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Lewis**
 (c) City or town **Canon**
 (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 **11**
 year **1940** hour **10** minute **30 a. M.**

21. I hereby certify that I attended the deceased from **May 23**, 19**40** to **May 11**, 19**40**
 that I last saw her alive on **May 11**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Postul. Corbaci**
with cancer

Due to **Primum Anemia** **3 yrs**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **10 11 13**

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?
Yes

While at work? _____ (Specify type of place)
 Means of injury _____

23. Signature **L. J. Hillard** (M. D. or other) **Dr.**
 Address **Washington Mo** Date signed **5-12-40**

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

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. 10

District File Number 6-40-1144

Date Filed JUN 7 1940

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.....

W. D. Kelly
....., Registered Apprentice No.....
working under my personal supervision.

Signed W. D. Kelly

Licensed Embalmer No. 1956

P. O. Address Canton, 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.