4

WRITE PLAINLY, 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 X14028

FILED JUN 22 1940

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

19429
Do not use this space.

1. PLACE OF DEATH
(a) County St. Francis 2 Registration District No. 33
(b) Township Randolph 0 Primary Registration District No. 6024B Registered No. 9
(c) City Frank Clay 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 425 Jesse Wilson
(a) Residence, No. Frankclay, Mo. St. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Amilda Wilson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 8-1844.
7. AGE Years 95 Months 10 Days 17. If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer.
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) Tennisee — 1

FATHER
13. NAME William Wilson 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennisee. 1

MOTHER
15. MAIDEN NAME Elizabeth Raines.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennisee.

17. INFORMANT (ADDRESS) Mrs. Frank Foster. Frank Clay Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Shirley Mo. DATE 5-27- 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J B Bayer & Son Potosi, Mo.
20. FILED 6/6, 1940 W E Aubuchon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25, 1940.
22. I HEREBY CERTIFY, That I attended deceased from May 16, 1940 to May 25, 1940
I last saw him alive on May 24, 1940. Death is said to have occurred on the date stated above, at 6 A. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Influenza Farynged & Bronchial	5/13 40
Broncho Pneumonia	5/20 40

Other contributory causes of importance: 11 W

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) W. P. Duckmarth, M. D.
(Address) Desloge Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

S. No. 2B
1—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19429

Registration District No. 33 Primary Registration District No. 6024B Registrar's No.

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Randolph Tp
(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: Residence Mo.
(a) State Frankclay Mo (b) County St Fran. Co
(c) City or town Frankclay, Mo
(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 Jesse Wilson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced widd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 95 Months 10 Days 7 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)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 7/10-1940 (Date received local registrar) (b) W E Aubuchon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions
(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?
(Specify type of place)
While at work (e) Means of injury

23. Signature W P Duckworth (M. D. or other)
Address Dellwood Mo Date signed

SUPPLEMENTARY

S-19429