

FILED JUN 22 1940

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

19806

Do not use this space.

## 1. PLACE OF DEATH

(a) County Wayne Registration District No. 891  
(b) Township Benton Primary Registration District No. 4540  
(c) City Piedmont (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

Elizabeth Wilson  
(a) Residence, No. Piedmont St. Pros  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Charles N. Wilson  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 30 1877  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
62 8 25  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) Wayne Co. Mo.  
13. NAME Eleana Donegan  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
15. MAIDEN NAME Martha Hickman  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
17. INFORMANT (ADDRESS) Mrs. Flynn Donegan  
Piedmont, Mo.  
18. BURIAL, CREMATION, OR REMOVAL PLACE Masonic Cemetery DATE May 27 1940  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) William R. Rader  
Piedmont, Mo.  
20. FILED 57 281, 1940 T. P. Piles M.D.  
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 5:25 1940, to 5:25 1940  
I last saw him alive on 5-25 1940. Death is said to have occurred on the date stated above, at 6:45 a.m.  
The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset 5-25  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? No 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) As James, M. D.  
739 (Address) Piedmont Mo.

(Licensed Embalmer's Statement on Reverse Slide)

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.

**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~~.....

*William Coder*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *William Coder*  
Licensed Embalmer No. *3723*  
P. O. Address *Piedmont, MD*

**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. 19806

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 891

Primary Registration District No. 4540

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Wayne

(b) City or town Piedmont  
(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..... (Specify whether  
In this community..... years, months or days)

3. (a) PRINT FULL NAME Elizabeth 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 w

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 62 Months 8 Days 25 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name Elegan E. Jurgan

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

14. Maiden name Margaret Heschman

15. Birthplace Wichita, Kan. (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) 5-28-1940 T. C. Ciles M.D. (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 May day 25 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.....

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?

23. Signature T. C. Ciles M.D. (M. D. or other) Address Piedmont, Mo.

