

SEP 19 1940  
Registration District No. 110

Primary Registration District No. 5541

Registrar's No. 3

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

1. PLACE OF DEATH:

(a) County Hawell  
(b) City or town Rural Silsoam Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
14 Miles N.W. of West Plains  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community: 12 years  
years, months or days

3. (a) PRINT FULL NAME Isaac R. Wilson 425

8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Laura 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased September 30 1851  
(Month) (Day) (Year)

8. AGE: Years 88 Months 9 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation farmer

11. Industry or business bank

12. Name John Wilson  
13. Birthplace unk 4  
(City, town, or county) (State or foreign country)

14. Maiden name Magline Roberts  
16. Birthplace unk 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Laura May Wilson  
(b) Address West Plains Missouri

17. (a) burial (b) Date thereof July 10 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Collins Cemetery  
Neighbors

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 7-12-40 (b) Mrs. Gladys Justa  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hawell  
(c) City or town rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. 14 Miles N.W. of West Plains  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7  
year 1940 hour 6 minute P M.

21. I hereby certify that I attended the deceased from of 30, 1940, to 7/3, 1940  
that I last saw him alive on 7/3, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Shock Duration 10 days

Due to Fracture of 2 femurs

Due to ruptured neck

Other conditions arterio-sclerosis  
(Include pregnancy within 3 months of death)

Major findings: Of operations X  
Of autopsy X  
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) accident

(b) Date of occurrence of 30/40

(c) Where did injury occur? home  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
351 (Specify type of place)

While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
23. Signature Walter Thompson (M. D. or other) M.D.  
Address West Plains Mo Date signed 7/17

1862  
97

RECEIVED

District Health Officer No. 5,

District File Number 840892

Date Filed \_\_\_\_\_

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. **28679**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **1110**

Primary Registration District No. **5341**

Registrar's No. ....

1. PLACE OF DEATH:

(a) County **Howell**  
(b) ~~Clinton~~ **Sisouan T.C.**  
(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 **Isaac P. 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 **m**

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 **88** Months **9** Days **9** 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 (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **July** day **9** year **1940** 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 **Shock** Duration

**fracture of l. femur**  
Due to \_\_\_\_\_

**surgical neck**  
Due to \_\_\_\_\_

Other conditions **aortic Regurgitation**  
(include pregnancy within 3 months of death)

Major findings: **Fracture l. femur** PHYSICIAN

Of operations. \_\_\_\_\_ Underline the cause to which death should be charged statistically.

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Accident**

(b) Date of occurrence **6/30/40**

(c) Where did injury occur? **Howell Co Mo** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Home**

While at work? **no** (Specify type of place) (e) Means of injury **Fall**

23. Signature **Maude Stuyvesant** (M. D. or other) **no**

Address **West Plains** Date signed **7/1/40**

SUPPLEMENTAL

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

