

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

Do not use this space.

29925

1. PLACE OF DEATH

County Jones Registration District No. 861
 Township Swack Primary Registration District No. 6132
 City (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 23

2. FULL NAME

475 Minnie Caroline Wilson

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17, 1940

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

22. I HEREBY CERTIFY, That I attended deceased from 8-1-, 1940, to 8-17-, 1940
 I last saw h. alive on 8-17-, 1940 Death is said to have occurred on the date stated above, at 5:00 AM

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-10-1879

The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 7 17

Date of onset Unknown

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Domestic
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:
121

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

Weg. Chini Borech
Hyperlipemia

FATHER 13. NAME Louis Houceman

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

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)

MOTHER 15. MAIDEN NAME _____

Specify whether injury occurred in industry, in home, or in public place. _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

Manner of injury _____
 Nature of injury _____

17. INFORMANT (ADDRESS) Oliver Wilson
Jones, Mo

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Wheeler, Mo DATE 8-18, 1940

(Signed) W. H. ... M. D.
 (Address) ...

19. UNDERTAKER (ADDRESS) J. N. ...

20. FILED Sept 10 1940 Gene B. Reynolds Registrar.

RECORD OR ENTRY IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

RECEIVED

District Health Officer No. 6,

District File Number 940-2586

Date Filed SEP 7 1945

No. 2B
2-21-40
X2283

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29926**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **861**

Primary Registration District No. **6132**

Registrar's No. _____

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

1. PLACE OF BIRTH:

(a) County **Janey**

(b) City or town **Swan**
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Janey**

(c) City or town **Forsyth - "Rural 2"**
(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 **Missie Caroline 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 **wid**

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **8** day **17**
year _____ 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.

8. AGE:

Years	Months	Days	If less than one day
61	2	12	hr. _____ min. _____

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

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

14. Maiden name _____

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

Major findings: _____

Of operations _____

Of autopsy _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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? _____

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

19. (a) **Sept 10 - 1940** (b) **Franz B. Reimer**
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

