U. S. No. 2
(—11-10-39
rev. 5-17-39)
Form I x-[illegible]

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Dr. Clark

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31748

OCT 12 1940

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 136

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

1. PLACE OF DEATH:

(a) County: Clay

(b) City or town: Excelsior Springs Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 724 Magnolia St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 0 (Specify whether
In this community: 20 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Clay

(c) City or town: Excelsior Springs
(If outside city or town limits write "RURAL")

(d) Street No.: 724 Magnolia St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME: CHARLES WILLS.

3. (b) If veteran, name war: No

3. (c) Social Security No.: No.

4. Sex: Male

5. Color or race: white

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: wife. Lyda Willy

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: June (Month) 9 (Day) 1871 (Year)

8. AGE: Years 69 | Months 2 | Days 22 | If less than one day: ✓ hr. ✓ min.

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

10. Usual occupation: Farmer & Hardware

11. Industry or business: ✓

MOTHER FATHER

12. Name: John Wills

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

14. Maiden name: Amanda Hon

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

16. (a) Informant: Gertabel Sherwood

(b) Address: Excelsior Springs Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 3-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Hampton Mo

18. (a) Signature of funeral director: Herbert Hope

(b) Address: Excelsior Springs Mo.

19. (a) 9/3/40 (Date received local registrar) (b) Mrs Real McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1st year 1940 hour 9 minute 45 A. M.

21. I hereby certify that I attended the deceased from 6/12, 1940, to 9/1, 1940, that I last saw him alive on Aug. 31, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Stomach & bowels.	about 10 Months
Due to: Tumor Mass in Stomach	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Carcinoma of Stomach
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: H. J. Clark (M. D. ~~or other~~) 1

Address: 246 E. Bdway Exc Springs Mo. Date signed 9-2-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-9-40

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 Virgil Hope

Licensed Embalmer No. 3950

P. O. Address Excelsior Springs

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.