

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32727

Registration District No. 625 OCT 23 1940

Primary Registration District No. 3091

Registrar's No. 128

1. PLACE OF DEATH:

(a) County Nodaway  
(b) City or town Marvville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Two weeks  
(Specify whether years, months or days) Thirty years.

3. (a) PRINT FULL NAME Mrs. Mattie Wilson

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Henry Wilson 6. (c) Age of husband or wife if alive No. years

7. Birth date of deceased March 24, 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
70 6 3 hr. \_\_\_\_\_ min.

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

10. Usual occupation House Maid

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name ? Jones

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

14. Maiden name Carrie Gray

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

16. (a) Informant's own signature Mrs. Gertie Parent

(b) Address Bartlettville Okla.

17. (a) Oak Hill (b) Date thereof Oct 2 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill

18. (a) Signature of funeral director Wm G

(b) Address Marvville Mo

19. (a) Oct 24 1940 (b) Mamie E. Chardy  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway  
(c) City or town Marvville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 420 W 5th St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 27 day 1940  
year \_\_\_\_\_ hour 8:30 P. minute 15 M.

21. I hereby certify that I attended the deceased from Sept 18  
1940, to Sept 27, 1940  
that I last saw he alive on Sept 27, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Pneumonia  
Due to Fracture of femur 2 wks  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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

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? \_\_\_\_\_

556 (Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. A. Blumer (M. D. or other) \_\_\_\_\_

Address Marvville Mo Date signed Oct 1 1940

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

1862  
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**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 *J. B. Cummings*

Licensed Embalmer No. *1675*

P. O. Address *Marysville, Wn.*

**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. **32727**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **625**

Primary Registration District No. **3031**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Madison**  
(b) City or town **Marionville**  
(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) **PRINCE**  
**FULL NAME** **Mrs Mattie Wilson**

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

4. Sex **7** 5. Color **Black** 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)

8. AGE: Years **70** Months **6** Days **3** 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 \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(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 **Sept** day **27** 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 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death: **Broncho pneumonia,**

**fracture of femur**

Due to \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death) **196W**

Major findings: Of operations: **18**

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) **Fell down steps**  
(b) Date of occurrence **Sept 18-1940**  
(c) Where did injury occur? **her home** (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **her home**

While at work? **business** (Specify type of place) (e) Means of injury **fall**

23. Signature **J. B. Blaine** (M. D. or other)

Address **Marionville Mo** Date signed **11/29/40**

SUPPLEMENTARY

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

MOTHER FATHER

