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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42454

State File No. _____

JAN 15 1940

Registration District No. 1104

Primary Registration District No. 5415

Registrar's No. 20

1. PLACE OF DEATH:

(a) County: Franklin Mo.

(b) City or town: Beaufort Mo.

(c) Name of hospital or institution: Home
(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) Sixty days yrs 0 mo 2
23 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Franklin

(c) City or town: Beaufort Boone
(If outside city or town limits, write "RURAL")

(d) Street No.: R.T.S. Gerald Mo.
(If rural, give location)

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

8. (a) PRINT FULL NAME: LILLY L WILSON

8. (b) If veteran, name war: X

8. (c) Social Security No.: X

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: X

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

7. Birth date of deceased: May 30 1873
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25
year 1940 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 14, 1940 to Dec 25, 1940
that I last saw her alive on Dec 25, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

67 6 23 hr. _____ min.

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

10. Usual occupation: House Keeping

11. Industry or business: _____

12. Name: John Wilson

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

14. Maiden name: Sarah West

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

Immediate cause of death: Acute Bronchitis Duration 15 days

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: Emma Wilson

(b) Address: Beaufort Mo.

17. (a) Burial: (b) Date thereof: 12-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St Paul Beaufort Mo.

18. (a) Signature of funeral director: [Signature]

(b) Address: [Address]

19. (a) 12/26/40: (b) [Signature]
(Date received by registrar) (Registrar's signature)

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? _____

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

23. Signature: [Signature] (M. D. _____)

*Address: Beaufort Mo. Date signed: 12/18/40

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

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

Robert M. Murray

Licensed Embalmer No.

3749

P. O. Address

Owensville, Mo.

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.