FILED MAR 14 1941

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

6789
Do not use this space.

1. PLACE OF DEATH
(a) County Dallas — Registration District No. 241
(b) Township or City Buffalo 1 — Primary Registration District No. 4141 — Registered No. 1270
(c) (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bertha Elizabeth Wilkinson
(a) Residence, No. Buffalo Mo St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John R. Wilkinson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 10 - 1877
7. AGE YEARS 63 MONTHS 7 DAYS 24 If LESS than 1 day, ... hrs. or ..... min.

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

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

FATHER
13. NAME Roley Stavens
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Johnson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Daviess Co Iomo

17. INFORMANT (ADDRESS) John R. Wilkinson Buffalo Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 2-6 1941
19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones
20. FILED 3 March 10, 1941 [illegible] Morrow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-4, 1941
22. I HEREBY CERTIFY, That I attended deceased from 1-5-, 1941, to 2-4-, 1941
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 11:00 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
asthma	?
Other contributory causes of importance: Myocardial degeneration	?

Name of operation None Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? —
If so, specify .....
(Signed) R. E. Harrell, M. D.
(Address) Buffalo, Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

50M-9-19-38 I X16605

RECEIVED
District Health Officer No. 7,
District File Number 3-41-521
Date Filed 3-12-41

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.

S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6789

Registration District No. 241 Primary Registration District No. 4147 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town Buffalo
(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

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.

3. (a) PRINT FULL NAME Bertha Elizabeth Wilkinson
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
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 years
7. Birth date of deceased June (Month) 10 (Day) 187 (Year)

8. AGE: Years 63 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Dallas Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name Baly Stevens
13. Birthplace Ind (City, town, or county) (State or foreign country)
14. Maiden name Johnson
15. Birthplace Dallas Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1/10 1941 (Date received local registrar) (b) Harvey Morrow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 4 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature R. E. Hanell (M. D. or other)
Address Buffalo Mo Date signed

SUPPLEMENTARY