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FILED SEP 10 1941 85
Registration District No. _____

Primary Registration District No. **5127**

Registrar's No. **833**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Industrial City Rural Washington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Highway K.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 85 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Industrial City Rural Washington
(If outside city or town limits, write "RURAL")
(d) Street No. Highway K. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18
year 1941 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from
July 2, 1941, to Aug 18, 1941;
that I last saw her alive on Aug 18, 1941;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Pellary Blisters
Due to abscess of skin + old age

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature W. H. Brown (M. D. or other) _____
Address Logan Bldg. St. Joseph, Mo. Date signed 8-18-41

3. (a) PRINT FULL NAME Rilla Wade Stilwell

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife John W. Stilwell 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 22 1856
(Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 26 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Home

12. Name Edmund Wade

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

14. Maiden name Elizabeth Rawlings

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

16. (a) Informant Mrs. R. O. Powellson
(b) Address St. Joseph, Missouri

17. (a) Burial (b) Date thereof August 20, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Memorial Park Cemetery St. Joseph, Mo.
18. (a) Signature of funeral director Walter Meierhoffer
(b) Address 1302 Faraon St. St. Joseph, Mo.
19. (a) Aug 19, 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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

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

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.....

My-self
....., Registered Apprentice No.
working under my personal supervision.

Signed *Robert P. Carlson*

Licensed Embalmer No. *4028*
820 July
P. O. Address *St Joseph, 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, fact should be so stated above.