

FILED SEP 17 1941 34

Registration District No. \_\_\_\_\_

Primary Registration District No. 6026

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

1. PLACE OF DEATH:

(a) County St. Genevieve  
(b) City or town Rural Union Township  
(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) PRINT FULL NAME BARBARA WILSON

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife C. WILSON 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JAN 21 1866  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace HUNGARY EUROPE  
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

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

12. Name C. WAER

13. Birthplace HUNGARY EUROPE  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace BARBARA SCHIEB EUROPE  
(City, town, or county) (State or foreign country)

16. (a) Informant Dominic Lichtner

(b) Address Passington Mo

17. (a) Rural (b) Date thereof Sept 9 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blomdale Mo

18. (a) Signature of funeral director Geo. C. Gash

(b) Address St. Genevieve Mo

19. (a) Sept 15 41 (b) Rev. Joseph G. Garrison  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Genevieve 95  
(c) City or town Rural  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month SEPT day 6  
year 1941 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from 8-30-1941  
9-6-1941 to 9-6-1941  
that I last saw her alive on 9-6-1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 7 da.

Due to Arteriosclerotic heart disease & Arteriosclerosis 34 yrs

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 Geo. H. Williams (M. D. or other) 0

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

935  
0  
C

**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.....

*Lee C. Baskin*....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Lee C. Baskin*.....

Licensed Embalmer No. *1985*

P. O. Address..... *St. Germaine 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.**