

Registration District No. 4209

Primary Registration District No. 3022

1. PLACE OF DEATH:

(a) County Jefferson  
(b) City or town Desoto  
(c) Name of hospital or institution:  
none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether years, months or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Desoto  
(If outside city or town limits, write "RURAL")  
(d) Street No. 57th St.  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A? 0 years.

3. (a) PRINT FULL NAME

Benjamin Baley Wilkinson

(b) If veteran, name war no

(c) Social Security No. 702-16-037

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Edna Baley Wilkinson 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased April - 20 - 1873  
(Month) (Day) (Year)

8. AGE: Years 68 Months 4 Days 27  
If less than one day hr. min.

9. Birthplace Washington Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Ret. Carpenter

11. Industry or business B & B Carpenter Mo. Pac.

12. Name Joseph Wilkinson

13. Birthplace in known  
(City, town, or county) (State or foreign country)

14. Maiden name Anne Martin

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

16. (a) Informant W. P. Wilkinson

(b) Address 6271 St. Louis Ave. #111

17. (a) burial (b) Date thereof Sept. 19 - 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Desoto

18. (a) Signature of funeral director Rev. Motherhead

(b) Address Desoto Mo

19. (a) 9-17-41 (b) Fern Spencer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17  
year 1941 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death by natural causes, unknown to this jury Duration \_\_\_\_\_

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 9

23. Signature W. P. Wilkinson (M. D. or other)

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

WHILE FILING - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

39  
9  
492

**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.....

.....  
working under my personal supervision.

..... Registered Apprentice No. ....

Signed

*J. E. Matherhead*

Licensed Embalmer No. *3531*

P. O. Address *2470 N. M.*

**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.**

2B  
21-41  
K29288

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31843

Registration District No. 420

Primary Registration District No. 3022

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

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Osceola  
(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 Benjamin B. Wilkinson

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

4. Sex m 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 \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (Burial, cremation, or removal) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ days on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Causes unknown to the jury  by natural  
Duration \_\_\_\_\_

Due to possibly Coronary Thrombosis  
Due to no medical attention

Other conditions not called after death  
(Include pregnancy within 3 months of death)

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

Of autopsy gfa  
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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

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

SUPPLEMENTARY

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

MOTHER FATHER

S-31843 1941