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K28390

FILLED OCT 11 1940

State File No. _____

Registration District No. _____

Primary Registration District No. 5929

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Walnut Grove

(c) Name of hospital or institution: Jackson Twp Rural

(d) Length of stay: In hospital or institution 70 (Specify whether years, months or days)

In this community 3.5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Walnut Grove

(d) Street No. Rural, Jackson Twp

(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME CLARA Jane Wilson

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 10 year 1941 hour 5 minute 30 a.m.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Claborn M. Wilson

6. (c) Age of husband or wife if alive 1864 years

7. Birth date of deceased: July (Month) 2 (Day) 1864 (Year)

21. I hereby certify that I attended the deceased from Aug-1-1940 to Sept-10-1941 that I last saw him alive on Aug-17-1941 and that death occurred on the date and hour stated above.

8. AGE: Years 77 Months 2 Days 8 If less than one day hr. min.

Immediate cause of death Chronic Endocarditis

Due to _____

Due to _____

9. Birthplace Ottumwa Iowa

10. Usual occupation housewife

11. Industry or business General Store work

12. Name Jephthiah Brown

13. Birthplace Indiana

14. Maiden name Mary Ann Coburn

15. Birthplace Indiana

16. (a) Informant Mrs Pearl Mackey

(b) Address Walnut Grove Mo R3

17. (a) Rural (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Oswill Cemetery

18. (a) Signature of funeral director Gene A. Parr

(b) Address Walnut Grove Mo.

19. (a) Sept-12-1941 (b) Wynne Miller

Other conditions 92%

(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy no

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? _____

(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. J. Myran (M. D. or other) _____

Address apex mo Date signed 9/12/41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District Number 10-41-1716

Date Filed 10-6-41

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.....

Gene A. Bair

Licensed Embalmer No. 7660

P. O. Address Franklin Ave. N.

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.