

FILED MAR 15 1942

Registration District No. ....

Primary Registration District No. 3038

Registrar's No. 32

1. PLACE OF DEATH:

(a) County... SALINE  
 (b) City or town... MARSHALL  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
FitzGibbons  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline 97  
 (c) City or town... Arrow Rock  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. ? (If rural, give location)  
 (e) Citizen of foreign country? ? Life (Yes or No)  
 If yes, name country.....

3. (a) PRINT FULL NAME John Frank Wilson

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

4. Sex MALE 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased April 13 1888  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 10 1 hr. min.

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

10. Usual occupation FARMER

11. Industry or business.....

MOTHER FATHER { 12. Name unknown  
 13. Birthplace unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name unknown  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Pearl Banks  
 (b) Address Arrow Rock mo

17. (a) Burial (b) Date thereof Feb 17 1942  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nelson mo

18. (a) Signature of funeral director Don Short

(b) Address Marshall mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14  
 year 1942 hour 6:40 minute 10 M.

21. I hereby certify that I attended the deceased from Feb 10  
1942 to Feb 14 1942  
 that I last saw him alive on Feb 14 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death Auto Injury return land Duration 24 hrs

Due to.....  
 Due to..... 1356  
 Other conditions (Include pregnancy within 3 months of death)

Major findings: hyperaemic eye to lungs  
 Of operation.....  
 Of autopsy none

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 W. H. D. Marshall (M. D. 0)  
 Address Marshall mo Date signed 2-17-42

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 3-12-42.....

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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.....

*Donald W. Stout*

Licensed Embalmer No.....

*3757*

P. O. Address.....

*Marshall 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.

STANDARD CERTIFICATE OF DEATH

State File No. 79 72

Registration District No. 794

Primary Registration District No. 3038

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(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)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME John F. Wilson

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased Apr. 13 1888  
(Month) (Day) (Year)

8. AGE: Years 54 Months 10 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 \_\_\_\_\_ (City, town, or county) (State or foreign country)

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I or saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_ 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

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

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

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

MOTHER FATHER

SUPPLEMENTARY

S-7972