

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

FILED APR 24 1942

Registration District No. **6-25**

Primary Registration District No. **3031-5627**

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

74  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Nodaway

(b) City or town Wilcox, Mo.  
(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 1  
(Specify whether \_\_\_\_\_)

In this community 4 1/2 yrs.  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County Nodaway

(c) City or town Wilcox 074  
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_ 0

**3. (a) PRINT FULL NAME** William Henry

3. (b) If veteran, name war no

3. (c) Social Security No. no

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 1  
year 1942 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from April 1940 to April 1 1942  
that I last saw him alive on March 25 1942  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

(b) Name of husband or wife Bertha B.

6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased January 20 1862  
(Month) (Day) (Year)

Immediate cause of death Cerebral metastasis of carcinoma of prostate

Duration 2 yrs.

Due to Senility

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

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

Major findings: 516

Of operations \_\_\_\_\_

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

**8. AGE:**

Years	Months	Days	If less than one day
<u>80</u>	<u>2</u>	<u>11</u>	hr. _____ min. _____

9. Birthplace Page Co. Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

**MOTHER FATHER**

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

12. Name Thomas Henry

13. Birthplace Co. Down Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Rachel E. Mcintosh

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

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Clarence West

(b) Address Wilcox, Mo.

17. (a) Burial (b) Date thereof Apr. 3-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Braddyville Ia

18. (a) Signature of funeral director Price Funeral Home

(b) Address Maryville Mo.

19. (a) April 3, 1942 (b) Mary Cole  
(Date received local registrar) (Registrar's signature)

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) (Of means of injury)

23. Signature B. F. [unclear] (M. D. or other) MD

Address 131 S Main Maryville Date signed 4/7/42

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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..... *Clara M. Pisci*.....

Licensed Embalmer No. *1822*

P. O. Address..... *Maryville, 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.**