

S. No. 1-9-4-41  
5-17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38324

State File No. ....

FILED NOV 17 1942

Registration District No. 85-2381

Primary Registration District No. 6-12-46179

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Pollock Rural Jackson Twp  
(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 Lifetime years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan  
(c) City or town Pollock Rural Jackson Twp  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Amanda Melvina Wilks

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct, day 26, year 1942 hour 11 minute 30 P.M.  
21. I hereby certify that I attended the deceased from December 10, 1941, to Oct 26, 1942 that I last saw her alive on Oct 26, 1942 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Samuel Coleman Wilks 6. (c) Age of husband or wife if alive, 77 years  
7. Birth date of deceased: Sept. 16, 1866  
(Month) (Day) (Year)

Immediate cause of death: aneurysm of aorta  
hypertension  
Due to: arteriosclerosis & nephritis  
Due to: \_\_\_\_\_  
Other conditions: hypertrophic arthritis  
(Include pregnancy within months of death)

8. AGE: Years 76 Months 1 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bradford Co. Penna. (City, town, or county) (State or foreign country)

10. Usual occupation at home

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

MOTHER FATHER { 12. Name John L. Merley

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Rebecca Barnett

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

16. (a) Informant Sam C. Wilks

(b) Address Pollock, Mo.

17. (a) burial (b) Date thereof Oct 28, 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Clayview Cem. Pollock

18. (a) Signature of funeral director Wm. W. Matranko  
(b) Address \_\_\_\_\_

19. (a) Nov. 7-1942 (b) Mrs. J. D. Green  
(Date received local registrar) (Registrar's signature)

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) Means of injury \_\_\_\_\_  
23. Signature Pat Buck (M. D. or other) D.O.  
Address \_\_\_\_\_ Date signed 10/26/42

Duration  
1 year  
20 years  
20 years  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 11-42-2083-

Date Filed NOV 16 1942

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.....

*Not Embalmed*

Registered Apprentice No.....

working under my personal supervision.

Signed *Frank D. Schwen*

Licensed Embalmer No. 2016

P. O. Address *Milwaukee*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38324

Registration District No. 381

Primary Registration District No. 6179

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

1. PLACE OF DEATH:

(a) County Sullivan  
 (b) City or town Beaufort  
 (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 Amende M. Wilke

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

4. Sex F 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 Sept 16 1914  
 (Month) (Day) (Year)

8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country) Penn

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER {

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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1992 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I or saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

(Immediate cause of death) aneurysm of artery Duration \_\_\_\_\_  
arterio-sclerosis 21 yrs  
myocarditis

Due to hypertrophic atherosclerosis of 30 years standing  
 Other conditions Myocarditis infection  
 (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 Chas. H. Judd (M. D. or other) D.O.

Address Gallatin, Mo Date signed 1-7-92

SUPPLEMENTARY

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

