

ED OCT 7 1943

Registration District No. **30725287**

Registrar's No. **330**

on account of new help... just turned...
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Clay**

(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **02 mi. south of Excelsior Springs Mo**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community **all of life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Clay** ²⁴

(c) City or town **Rural** ⁰
(If outside city or town limits, write "RURAL") ⁰

(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 **William Franklin Wilson**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30** ²
year **1943** hour **9:00** minute **9** A.M.

4. Sex **male** 5. Color or race **W**

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

6. (b) Name of husband or wife **Margaret**

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

7. Birth date of deceased **July 29 1876**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **suicide** Duration _____

8. AGE: Years Months Days If less than one day

67 0 1 hr. min.

Due to **Dispossession of health** ⁶⁴

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation **Retired farmer**

Major findings: Of operations **Crown**

11. Industry or business _____

Of autopsy **Case**

12. Name **John M. Wilson**

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

13. Birthplace **Lenna Tenn**
(City, town or county) (State or foreign country)

14. Maiden name **Eveline O Dell**

15. Birthplace **Ray Co Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Emma Mills**

(b) Address **Excelsior Springs, Mo.**

17. (a) **Burial** (b) Date thereof **Aug 1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **new Burial - Ray Co**

18. (a) Signature of funeral director **Clarence Richard**

(b) Address **Excelsior Springs Mo**

19. (a) **9-15-43** **Mrs Sadie Redman**
(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) **Suicide**

(b) Date of occurrence **July 30 1943**

(c) Where did injury occur? **Excelsior Springs Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On farm - Home
(Specify type of place)

While at work? _____ (e) Means of injury **Revolver**

23. Signature **P. W. Pracher** (M. D. or other) **Crown**

Address **Excelsior Springs Mo** Date signed **7-30-43**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

10-2-43

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

Carl Rapp

Licensed Embalmer No.

3458

P. O. Address

Excelsior Springs

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 928

Registration District No. 71 Primary Registration District No. 3012

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

1. PLACE OF DEATH:

(a) County Clay 2 mi S of Ex Spgs
(b) City or town Rural, Excelsior Spgs, Mo
(c) Name of hospital or institution: Fishing River Nursing
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Wm Franklin Wilson

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 July 29 (Month) (Day) (Year) 1900

8. AGE: Years 67 Months 0 Days _____ If less than one day _____ min.

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

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mrs Sadie Redman (Registrar's signature)

(Date received local registrar)

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 July of 1943 year. Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

31469