

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6694**
Registrar's No. **58**

FILED MAR 8 1944

Registration District No. **42**

Primary Registration District No. **5135**

1. PLACE OF DEATH:

(a) County **Butler**
(b) City or town **Broseley Rt 1**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
rural - ash Hill Top
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether)
In this community **3 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **Butler**
(c) City or town **Broseley**
(If outside city or town limits, write "RURAL")
(d) Street No. **R 1**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... **0**

3. (a) PRINT FULL NAME **Louise Wilson**

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 **Ralph Wilson** 6. (c) Age of husband or wife if alive **43** years
7. Birth date of deceased **Oct. 11 1904**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 4 3 hr. min.

9. Birthplace **Butler County Mo. 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER
{ 12. Name **Fred Liskey**
{ 13. Birthplace **St. Louis Mo. 0**
(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 **Ralph Wilson**

(b) Address **Broseley, Mo.**

17. (a) (Burial, cremation, or removal) (b) Date thereof **2-16-44**
(Month) (Day) (Year)

(c) Place: burial or cremation **Hole Hill**

18. (a) Signature of funeral director **Lloyd Russell**

(b) Address **Piggott, Ark**

19. (a) **2-19-44** (b) **Belle Stenne**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **16**
year **44** hour..... minute..... M.

21. I hereby certify that I attended the deceased from **Feb 10 - 19 44** to **Feb 16 19 44**
that I last saw her alive on **Feb 10 19 44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Womb**
Due to **stated on Cert**
Due to.....

Other conditions (Include pregnancy within 3 months of death) **48a**

Major findings of operations **Radiant**
Barand Skin Conca Hospital
Of autopsy.....

Duration

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) Manner of injury **3**

23. Signature **J. C. ...** (M. D. or other) **Dr.**
Address **Milledgeville** Date signed **Feb 18 44**

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

RECEIVED

District Health Office No. 2,

District File Number 344-380

Date Filed 3-3-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.