

FILED MAY 15 1944
340

Registration District No.

Primary Registration District No. 6152

Registrar's No. 14

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

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Bernie Rural
(c) Name of hospital or institution: 1
(d) Length of stay: In hospital or institution. _____
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Bernie Rural
(d) Street No. _____
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME Elizabeth Florence Wilson

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thos. J. Wilson 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased April 18 1878

8. AGE: Years Months Days If less than one day
65 11 19 hr. min.

9. Birthplace Prentiss Co. Miss.

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name John Glover
13. Birthplace No Record
14. Maiden name No Record
15. Birthplace No Record

16. (a) Informant Thos. J. Wilson
(b) Address Bernie, Mo.

17. (a) Burial (b) Date thereof 4-8-44
(c) Place: burial or cremation Bernie, Mo.

18. (a) Signature of funeral director Blankenship-Strickland
(b) Address Dexter, Mo.

19. (a) 4-16-1944 (b) Cardie Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1944 hour 8 minute 30 a.m.

21. I hereby certify that I attended the deceased from 9-23-42
19. to 4-6-44 19. that I last saw her alive on 4-6-44 19. and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions Chronic Hypertension

Major findings: Of operations 93d
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? _____
(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 F. O. Kelley (M. D. or other) DO
Address Bernie Mo Date signed 4-17-44

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

Dr. Kelly
B...

RECEIVED

District Health Office No. 2,

District File Number 544-732

Date Filed 5-11-44

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.