

FILED JUN 20 1944

State File No.

Registration District No. 48

Primary Registration District No. 5136

Registrar's No. 173

1. PLACE OF DEATH:

(a) County Butler
(b) City or town rural Bever Dam
(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
In this community 36yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butler
(c) City or town rural - Harviell
(If outside city or town limits, write "RURAL")
(d) Street No. at 14 67 junction
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas Wilson

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mattie B. Wilson 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Nov. 29 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 5 11 hr. min.

9. Birthplace St Louis Co. Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business

12. Name Leonidas Wilson
13. Birthplace St. Louis Co. Mo. D
(City, town, or county) (State or foreign country)
14. Maiden name Dorothy Price
15. Birthplace Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Dorothy Belamy
(b) Address Harviell, Mo.

17. (a) Burial (b) Date thereof 5/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kinsey

18. (a) Signature of funeral director Minnie Gish
(b) Address Naylor, Mo

19. (a) 5/24/44 (b) Belle Kinsey
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month may day 10
year 1944 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from May 9
1944 to May 10 1944
that I last saw him alive on May 9
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage caused by injury from a fall
Duration

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

Major findings:
Of operations
Of autopsy
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) Shock
(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 J J Farr (M. D. or other) ✓
Address Harviell Date signed

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

RECEIVED

District Health Office No.

District File Number 644-86

Date Filed 6-14-4

Handwritten scribbles and illegible text.

Handwritten notes, possibly including a name and address, but mostly illegible.

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

Bryan M. C. Cord

Licensed Embalmer No. 4079

P. O. Address Wayton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Handwritten signature or initials at the bottom right.

Registration District No. *43*

Primary Registration District No. *5136*

1. PLACE OF DEATH:

(a) County *Butler*
(b) City or town *rural near Day Twp*
(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)

3. (a) PRINT FULL NAME *Thomas 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 *Nov 29 1880*
(Month) (Day) (Year)

8. AGE: Years *84* Months *5* Days *18* (less than one day) min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

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* day *19* year *1944* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *1944* to *1944* that I last saw him *alive* on *July 19* and that death occurred on the date and hour stated above.

Immediate cause of death *Cerebral hemorrhage caused by injury from a fall*
Due to *shock*
Due to *shock*

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

Major findings: Of operations *ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED* *175 hr*
Of autopsy *3*

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) *fall*
(b) Date of occurrence *May 9*
(c) Where did injury occur? *Home* (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Thrown into lane by Bull*
While at work? *yes* (Specify type of place) (e) Means of injury
23. Signature *J. J. Garrison* (M. D. or other) *16/24/44* Date signed

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

SUPPLEMENTARY

MOTHER FATHER

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

1973

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