

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

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Ridgeway
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community two weeks
years, months or days)

3. (a) PRINT FULL NAME BLUFORD WILSON

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

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced widowed

(b) Name of husband or wife Edith Wilson
6. (c) Age of husband or wife if alive 59 ✓

7. Birth date of deceased Dec 11 1959
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 9
If less than one day hr. min.

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

10. Usual occupation Labour

11. Industry or business

12. Name John Wilson

13. Birthplace no record
(City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant Maralee Wilson

(b) Address Ridgeway - Mo. 22, 1944

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

(c) Place: burial or cremation LEON, IOWA

18. (a) Signature of funeral director Frank S. Stewart

(b) Address Leon, Iowa

19. (a) 4-22-44 (b) L. Drewes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Decatur
(c) City or town Decatur City
(If outside city or town limits, write "RURAL")
(d) Street No. no
(If rural, give location)
(e) Citizen of foreign country? no ✓ (Yes or No)
If yes, name country no ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20
year 1944 hour 3 minute 00 A.M.

21. I hereby certify that I attended the deceased from April 15, 1944, to April 20, 1944;
that I last saw him alive on April 20, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death coronary valve
& muscular disease & chronic
hypertension

Due to 121

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 no

23. Signature Dr. B. T. ... (M. D. or other) Dr.
Address Ridgeway, Mo. Date signed 4-20-44

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

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..... *Frank S. Stewart*

Licensed Embalmer No..... *3756*

P. O. Address..... *Leon Iowa*

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.