

No. 2
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5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3021**

Registration District No. **268**

Primary Registration District No. **1906**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Pemisco**

(b) City or town **WARDELL - 190 "RURAL"**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Little River Hosp**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) _____

In this community _____ years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **PEMISCO**

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

(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 **MABEL VIRGLE 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 **SINGLE**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **April 1 1922**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1-26** - day **26**
year **1945** - hour **5:30** minute **A.M.**

21. I hereby certify that I attended the deceased from **Jan 1** 19**45**, to **Jan 20** 19**45**
that I last saw **her** alive on **Jan 20** 19**45**
and that death occurred on the date and hour stated above.

8. AGE: Years **22** Months **9** Days **25** If less than one day _____ hr. _____ min.

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

Immediate cause of death **Natural regurgitation** Duration **3 yr**

Due to _____

Due to _____

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

11. Industry or business _____

MOTHER FATHER { 12. Name **William Wilson**

{ 13. Birthplace **UNKNOWN ALABAMA**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **CARRIE HODGES**

{ 15. Birthplace **UNKNOWN ALABAMA**
(City, town, or county) (State or foreign country)

16. (a) Informant **William Wilson**

(b) Address **WARDELL, MO**

17. (a) **Burial** (b) Date thereof **1-27-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WARDELL, MO**

18. (a) Signature of funeral director **WARDELL FUNERAL HOME**

(b) Address **WARDELL, MO**

19. (a) **27 1945** (b) **J. A. Cray**
(Date received local registrar) (Registrar's signature)

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 **5**

23. Signature **J. A. Cray** (M. D. or other) _____
Address **Wardell** Date signed _____

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

1-45-10

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 268

Primary Registration District No. 5906

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pemissot
(b) City or town Rural Little River Ins
(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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Mabel U. 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 S

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

7. Birth date of deceased April 1 (Month) (Day) (Year)

8. AGE: Years 22 Months 9 Days 3 If less than one day _____ min.

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

10. Usual occupation

Housekeeper

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 Jan Day 26 Year 1945 Minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

3021