

FILED MAR 13 1945
340

State File No. _____

Registration District No. _____

Primary Registration District No. 6152

Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural, S. Bond, Mo.
(c) Name of hospital or institution: St. Home
(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 Larnie P. Wilson

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

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jesse Wilson Age of husband or wife if alive 52 years

7. Birth date of deceased April 7 1904
(Month) (Day) (Year)

8. AGE: Years 40 Months 10 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Lee Co. Ark. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Paul

13. Birthplace North Carolina (City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Jesse Wilson

(b) Address Malden, Mo. R. # 2.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Hexter, Mo.

18. (a) Signature of funeral director Drum Funeral Home

(b) Address Berlin, Mo.
19. (a) 2-28-45 (Date received local registrar) (b) Carrie Miller (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20 year 1945 hour 10 o'clock minute _____ A. M.

21. I hereby certify that I attended the deceased from 2-15 1945 to 2-20 1945 that I last saw her alive on 2-15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration Duration 1 day

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dawsey Ryan (M. D. or other) _____
Address Berlin Mo Date signed 2-21-45

RECEIVED

District Health Office No.

District File Number 345-32

Date Filed 3/8/44

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

J. S. Shannon

Licensed Embalmer No. 4086

P. O. Address Malden

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. 112724
Registrar's No.

Registration District No. 340

Primary Registration District No. 6152

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural Liberty
(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 (Specify whether _____)

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 _____

3. (a) PRINT FULL NAME

Carrie P. Wilson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race B 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 April (Month) 12 (Day) 1895 (Year)

8. AGE: Years 40 Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1945 hour _____ minute _____ M.

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

Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) neither at home nor in
(b) Date of occurrence 2-20-45 9 a.m.
(c) Where did injury occur? Rural Stoddard Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

While at work? _____ (Specify type of place)
(e) Means of injury None

23. Signature Dawsey Ryan (M. D. or other) _____
Address Berlin Mo. Date signed 3-22-45

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

SUPPLEMENTARY

7353

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7353

Registration District No. 340

Primary Registration District No. 6152

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural - Liberty Imp
(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

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 _____

3. (a) PRINT FULL NAME Carrie P. Wilson

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

4. Sex F 5. Color or race B 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 April 7 (Month) (Day) (Year)

8. AGE: Years 40 Months 10 Day _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day _____ year 1945 hour _____ minute _____ M.

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

Due to _____
Due to _____

Other conditions Fatal Syncope owing to relaxation of the heart (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____

Of autopsy _____ 1945

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 Dawsey Ryan (M. D. or other) _____
Address Bernie Mo Date signed 5/24-45

SUPPLEMENTARY

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

