

FILED MAY 9 1945  
Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Stella  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Cardwell Hospital  
(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 Arkansas (b) County Washington  
(c) City or town Gateway  
(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 Luke 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 Jennie Wilson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 22 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>11</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Ellit County Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Service Station Operator

11. Industry or business Gasoline Distributor

MOTHER FATHER

12. Name Pleas Wilson

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

14. Maiden name Charlotte Lewis

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

16. (a) Informant Mrs. Jennie Wilson

(b) Address Gateway, Arkansas

17. (a) Removal (b) Date thereof April 21 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland, Kentucky

18. (a) Signature of funeral director W. Harrison

(b) Address \_\_\_\_\_

19. (a) 5-5-1945 (b) Alphe R. Hale Byer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20  
year 1945 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from 4-19-1945 to 4-20-1945  
that I last saw him alive on 4-20-1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Strangulated descending Coloph  
Duration 7 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 122

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) Means of injury 0

23. Signature Cardwell (M. D. or other) \_\_\_\_\_

Address Stella Mo Date signed 2/5/45

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

**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.

**RECEIVED MAY 7 1945**

District Health Officer No. ....

District File Number 445-69

Date Filed MAY 7 1945

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.**