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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20966

State File No. \_\_\_\_\_

FILED JUL 13 1945

Registration District No. 257

Primary Registration District No. 3048

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Madaway

(b) City or town Marionville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St Francis 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 Mo. (b) County North

(c) City or town Shelbourn  
(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 Manford Jackson Wilson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 10  
year 1945 hour 10 minute 0 P. M.

21. I hereby certify that I attended the deceased from May 11 - 45  
\_\_\_\_\_, 19\_\_\_\_, to June 10, 19\_\_\_\_.

that I last saw him alive on June 10, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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 62 years

7. Birth date of deceased: Feb 21 1873  
(Month) (Day) (Year)

Immediate cause of death Heart failure Duration \_\_\_\_\_

Due to Obstruction stomach  
Ulcer of Esophagus

Due to Gastro Intestinal June 1-45

8. AGE: Years 72 Months 3 Days 19  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Gertrude Wilson

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

14. Maiden name Caroline Sharp

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

16. (a) Informant Jennie Wilson

(b) Address Shelbourn, Mo.

17. (a) Burial (b) Date thereof 6-13-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Luteston

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Front City, Mo.

19. (a) 6-16-45 (b) Cheryl Barber  
(Date received local registrar) (Registrar's signature)

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) \_\_\_\_\_

(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. M. Boyles (M. D. certificate)  
Address Marionville, Mo. Date signed 6-11-45

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

OCT 10 1947

STATEMENT BY LICENSED EMBALMER

F. 1

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

District Health Officer No. 11,

District File Number.....

Date Filed.....

Signed.....

*Arch C. Dunfee*

Licensed Embalmer No. 3252

P. O. Address. Grant City, Mo.

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.

Registration District No. 251

Primary Registration District No. 3048

1. PLACE OF DEATH:

(a) County No Daway  
(b) City or town Maryville  
(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 Manford J. Wilson

3. (b) If veteran, name war \_\_\_\_\_ (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 Feb 21 (Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 4 (Unless than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Iowa (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (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)

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 19 year 1955 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: In operable carcinoma of pylorus of stomach PHYSICIAN \_\_\_\_\_

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) \_\_\_\_\_

(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 [Signature] (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

