

S. No. 2
M-5-43
v. 5-17-39
P X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31633

State File No.

FILED OCT 12 1945
378

Registration District No. 378

Primary Registration District No. 4552

Registrar's No. 155

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

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mtn Grove
(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 Lifetime (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY CATHERINE 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 widowed

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

7. Birth date of deceased MAY 20, 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name ? 9

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

14. Maiden name ?

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

16. (a) Informant old Age Records

(b) Address Mtn. Grove, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/10/45
(Month) (Day) (Year)

(c) Place: burial or cremation Kennedy Cemetery

18. (a) Signature of funeral director E. Barber
(b) Address Mtn. Grove Mo

19. (a) 9-14-45 (Date received local registrar) (b) A. G. Ames (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wright
(c) City or town Mtn. Grove
(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 No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8th
year 1945 hour 5 minute 17 M.

21. I hereby certify that I attended the deceased from 2-5 to 9-9, 1945
that I last saw her alive on 9-7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Carcinoma Duration 6 mo.

Due to _____

Due to _____

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

Major findings: Of operations H/O

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 W.A. Craig Wood (M.D. or other)

Address Mountain Grove Date signed 9-14-45

1587

(Licensed Embalmer's Statement on Reverse Side)

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.....

R. H. Embalmed....., 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.