

FILED NOV 8 1945

Registration District No. **33**

Primary Registration District No. **3010**

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: South East Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether
In this community McClure Jec.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County Alexander
(c) City or town McClure Ill
(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

Hugh O Wilson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race _____

6. (a) Single ~~widowed, married, divorced~~

6. (b) Name of husband or wife Bulah

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

7. Birth date of deceased Dec 24 1885
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>10</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name August Wilson

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

14. Maiden name Southern Knott

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

16. (a) Informant Bob Wilson

(b) Address Pittsburg Penn

17. (a) Burial (b) Date thereof 10-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pana Ill

18. (c) Signature of funeral director J. G. Howell

(b) Address Cape Girardeau Mo

19. (a) 10-30-45 (b) C. G. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28
year 1945 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from Jan 1st 1945 to Oct. 28th 1945
that I last saw him alive on Oct. 28th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death interstitial nephritis (chronic) complicated with Diabetes mellitus
Due to _____
Duration 1 yr?
10 yrs

Due to _____
Other conditions (include pregnancy within 3 months of death) 61

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature J. B. Schult (M. D. or other)
Address Cape Girardeau Mo Date signed 10/30/45

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

RECEIVED

District Health Officer No. 4

District File Number 1145-1274

Date Filed 11-6-45

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 W. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau

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. 53 Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (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 _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Hugh O. Wilson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W. 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 24 1924
 (Month) (Day) (Year)

8. AGE: Years 59 Months 10 Days _____ (less than one day) min.

9. Birthplace _____ (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) _____ (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) 11-12-75 (Date received local registrar) C. B. Summers (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 Oct day 8 year 1995 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____
 that I last saw him/her alive on _____ 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 _____

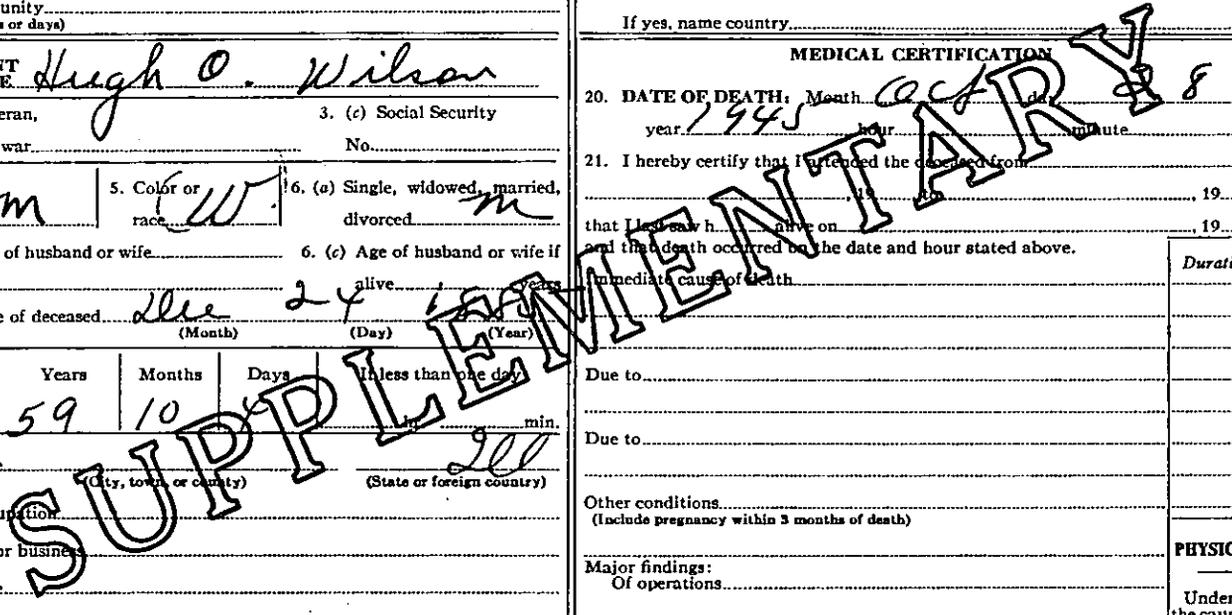
PHYSICIAN _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____



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

MOTHER FATHER

33415