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FILED OCT 27 1945

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 810

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 3 hrs.
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Noah Glen Wilkin
3. (b) If veteran, name war UNK. 3. (c) Social Security No. UNK.

4. Sex Male 5. Color or race whr 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Jessie Wilkin 6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased Oct 4, 1902
(Month) (Day) (Year)

8. AGE: Years 43 Months 0 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name Harlan Berner Wilkin
13. Birthplace UNK. Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Wife: Maa Randolph
15. Birthplace UNK. Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Jessie Wilkin
(b) Address CRANE MO.

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

(c) Place: burial or cremation AURORA, MO.

18. (a) Signature of funeral director J. F. King
(b) Address Aurora Mo.

19. (a) 10-10-45 (b) B. W. W. Huddley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barry
(c) City or town Crane Rural R. 1
(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 Oct day 9
year 45 hour 6 minute 45 P. M.
21. I hereby certify that I attended the deceased from Oct 9, 1945 to Oct 9, 1945
that I last saw him alive on Oct 9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Strained
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) _____
(e) Means of injury _____
23. Signature Walter Smith (M. D. or other) MD
Address Springfield, Mo. Date signed 10-9-45

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

DEC 17 1946

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 *Herman Surridge*

Licensed Embalmer No. *3072*

P. O. Address *Aurora 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 810

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(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 Noah S. Wilkins

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 on

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Oct 4 (Month) 1908 (Day) 1908 (Year)

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

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

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) (Date received local registrar) (b) (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 CERTIFICATE

20. DATE OF DEATH: Month Nov year 1945 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 1945 to 1945 that I last saw him alive on 11 and that death occurred on the date and hour stated above. Immediate cause of death Chronic nephritis

Due to Chronic nephritis

Due to

Other conditions (include pregnancy within 3 months before death)

Major findings: Of operations

Of autopsy

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) Manner of injury

23. Signature Walter Smith (M. D. or other)

Address Date signed

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER, FATHER

DEC 17 1946

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