No. 2
-5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37736

FILED NOV 17 1945

Registration District No. 1

Primary Registration District No. 5635

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

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

(c) Name of hospital or institution: 1 Union Hwy
(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 Missouri (b) County Laclede 53

(c) City or town Phillipsburg 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rural 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME BERT WILLS

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 8 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
74	5	14	hr. min.

9. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business

FATHER
12. Name Isaac Wills
13. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Caroline Baltzley
15. Birthplace Ohio (City, town, or county) 1 (State or foreign country)

16. (a) Informant Leo Wills

(b) Address Phillipsburg Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (Month) (Day) (Year)

(c) Place: burial or cremation Twilight Cemetery

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon Mo.

19. (a) Oct 30, 1945 (Date received local registrar) (b) Ora H. Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 22
year 1945 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Heart trouble	
Due to Suffocation ✓	
Due to Epileptic	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M.D. or other)

Address Lebanon Mo Date signed 10/23/45

1463

(Licensed Embalmer's Statement on Reverse Side)

Received .....

Laclede County Health Unit

File No. 10-45-148

Date Filed 11/15/45

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.

No. 2B
--3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. [illegible]

Registration District No. 170 Primary Registration District No. 5635 Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural Union Twp
(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)

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

3. (a) PRINT FULL NAME Bert Wills

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 8 (Day) 88 (Year)

8. AGE: Years 74 Months 5 Days 14 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct day 22
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to HAD EPILEPTIC FITS
LAYING WITH FACE IN PILLOW
Due to AND UNABLE TO TURN OVER

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 85

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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 R O Palmer Coroner (M. D. or other)
Address Lebanon Date signed 11/21/45

SUPPLEMENTARY

3TT36