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**FILED DEC 12 1945**

Registration District No. **27**

Primary Registration District No. **5910**

Registrar's No. **93**

1. PLACE OF DEATH:

(a) County Pemiscot  
(b) City or town Tyler  
(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 27  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemis cot  
(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 Lela Forsythe Wilson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (b) Name of husband or wife Jessie B. Wilson  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased December 7th 1890  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
54 9 8 hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name John A. McFarland  
13. Birthplace Alamo, Tenn.  
(City, town, or county) (State or foreign country)  
14. Maiden name Kattie Burns  
15. Birthplace Evansville, Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant O. H. Hundhausen  
(b) Address Tyler, Missouri  
17. (a) Burial (b) Date thereof 9-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cooter, Missouri

18. (a) Signature of funeral director H. S. Smith Funeral Home  
(b) Address Carrollton, Missouri  
19. (a) 11-23-45 (b) Christie P. Hicks  
(Date received local registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 15  
year 1945 hour 3 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from Sept 14  
to Sept 15 1945  
that I last saw h. in alive on Sept 14 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Due to Hypertension  
Duration \_\_\_\_\_

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?

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature J. Chapman (M. D.)  
Address Stark, Mo Date signed 9-15-45

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

11-45-214

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

*Bill Ford*

Registered Apprentice No.

*386*

working under my personal supervision.

Signed

*H. M. Cann*

Licensed Embalmer No.

*2727*

P. O. Address

*Parthenon, Ill.*

**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. 270Primary Registration District No. 5910Registrar's No. 93

## 1. PLACE OF DEATH

- (a) County Pemissot  
 (b) City or town Super Pemissot Sup  
 (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 Tela J. Wilson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced OR  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Dec 7  
 (Month) (Day) (Year)

8. AGE: Years 54 Months 9 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 \_\_\_\_\_  
 MOTHER FATHER  
 { 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) 12-19-45 (b) Christie B. Nicks  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Pemissot  
 (c) City or town Super  
 (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 \_\_\_\_\_ day \_\_\_\_\_  
 year 1945 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:  
 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

38146