S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED JAN 14 1946

State File No. 40415

Registration District No. 13 — Primary Registration District No. 5055 — Registrar's No. 100

1. PLACE OF DEATH:

(a) County: Barry

(b) City or town: Purdie (Rural) Capps Creek
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3 Miles South
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 35 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Lawrence
(c) City or town: Aurora Mo
(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: Dora Belle Wilks

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: widowed

6. (b) Name of husband or wife .....

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

7. Birth date of deceased: Feb 15 (Month) 1867 (Day) (Year)

8. AGE: Years 78 Months 10 Days 6 If less than one day ..... hr. ..... min.

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

10. Usual occupation: House wife

11. Industry or business .....

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

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Bertie Wilks
(b) Address: Aurora Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/24/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Springview Cemetery

18. (a) Signature of funeral director: Orlan T. Marsh
(b) Address: Aurora Mo

19. (a) 12-24-45 (Date received local registrar) (b) W. M. West (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22 year 1945 hour 8 minute 25 A.M.

21. I hereby certify that I attended the deceased from Dec 18, 1945 to Dec 22, 1945 that I last saw her alive on Dec. 18, '45, 19..... and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hemiplegia	4 days
Due to: Cerebral hemorrhage.	
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature: F. Avery Watson D.O.
Address: Sarcoxie, Mo Date signed 12-27-45

1608 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 146-66
Date Filed JAN 11 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 Myself, Registered Apprentice No. ....., working under my personal supervision.

Signed Oscar L. Marsh

Licensed Embalmer No. 3812

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.