

S. No. 2  
OM-2-43  
v. 5-17-39  
X35697

2387

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
**FILED FEB 8 1946 STANDARD CERTIFICATE OF DEATH**

State File No. \_\_\_\_\_

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 41

16  
14  
365  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:  
St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hours  
(Specify whether years, months or days)

In this community 8 hr  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard / 103

(c) City or town Bloomfield / 2  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 1  
(Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN WILSON, H.D.

3. (b) If veteran, name war 1st World

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Verl Wilson

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

7. Birth date of deceased AUG. 9 1885  
(Month) (Day) (Year)

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

60	5	15	ht. _____ min.
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9. Birthplace Stoddard Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Doctor

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

MOTHER FATHER { 12. Name P. G. Wilson

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

14. Maiden name Mary Yeargin

15. Birthplace Not Known  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Wilson (Son)

(b) Address Flat River, Missouri

17. (a) Burial (b) Date thereof Jan. 27-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Missouri

19. (a) 1-30-1946 (b) C. C. Summers  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 24th  
year 1946 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 23 1946 to Jan 24 1946  
that I last saw him alive on Jan 23 1946  
and that death occurred on the day and hour stated above.

Immediate cause of death Coronary thrombosis 2 days

Due to Arterial sclerosis ?

Due to \_\_\_\_\_

Other conditions 940  
(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 P. A. Ritter, M.D. (M. D. or other) \_\_\_\_\_  
Address Cape Girardeau, Mo. Date signed 1-29-46

4  
-246-1676  
2-7-46

NOV 7 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, OKB

REGISTERED APPRENTICE NXX

working under my personal supervision.

Signed Juan C. Bojner

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.