

S. No. 2  
DOM-8-43  
Rev. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

124332

FILED MAY 9 1946

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

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 162

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:  
State Hospital no 1 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month 4 days  
(Specify whether years, months or days)

In this community second month

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 14

(c) City or town Jefferson 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 106 S. Jefferson 2  
(If rural, give location)

(e) Citizen of foreign country? None 0 (Yes or No)

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

3. (a) PRINT FULL NAME C. C. WILSON

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22 year 1946 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 18 month 18 1946 to April 22 1946 that I last saw her alive on April 20 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 940

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

8. AGE: Years 65 Months 5 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: (City, town, or county) no Monticello (State or foreign country) Mo

10. Usual occupation attendant State Hosp

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

MOTHER FATHER { 12. Name OK

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

14. Maiden name OK

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) 9

16. (a) Informant Walter P. Beard

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof Apr. 28. 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eldon, Mo

18. (a) Signature of funeral director Glen Y. Mansin

(b) Address 712 Cant St. Fulton, Mo

19. (a) 4-22-1946 (b) Joak M. Mouskoff  
(Date received local registrar) (Registrar's signature)

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 W. P. Beard (M. D. or other) \_\_\_\_\_

Address Fulton, Mo Date signed 4/22/46

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

14  
1  
2

11341

RECEIVED

District Health Officer No. 9,

District File Number \_\_\_\_\_

Date Filed 5-8-46

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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 \_\_\_\_\_

*Glen Y. Marpin*

Licensed Embalmer No. \_\_\_\_\_

*2725*

P. O. Address \_\_\_\_\_

*Fulton 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.**