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DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
**LED AUG 2 1946**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26087**  
Registrar's No. **17**

Registration District No. **370**

Primary Registration District No. **6258**

1. PLACE OF DEATH:  
(a) County **Wayne**  
(b) City or town **RURAL - ST. FRANCOIS**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **Lifeline**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Wayne**  
(c) City or town **Greenville**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **CLARENCE MADISON WILSON**  
(b) If veteran, name war **no**  
(c) Social Security No. **442-07-8992**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **July** day **23** year **1946** hour **11** minute **10 P.M.**  
21. I hereby certify that I attended the deceased from **July 17** 19**46** to **July 23** 19**46**  
that I last saw him alive on **July 23** 19**46**  
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **married**  
(b) Name of husband or wife **Bessie**  
6. (c) Age of husband or wife if alive **46** years  
7. Birth date of deceased **Sept. 22 1891**  
(Month) (Day) (Year)

Immediate cause of death **Broncho-Pneumonia**  
Duration **10 days**

8. AGE: Years **54** Months **10** Days **1**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **TASKEE MO.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business **PIPEFITTER**

12. Name **MATT WILSON**

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

14. Maiden name **UNKNOWN**

15. Birthplace **II**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Bessie Wilson**

(b) Address **Greenville Mo**

17. (a) **Burial** (b) Date thereof **July 25 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rural**

18. (a) Signature of funeral director **G. S. Marshall**

(b) Address **Greenville**

19. (a) **July 28 - 46** (b) **Mabel Beasley**  
(Date received local registrar) (Registrar's signature)

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

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

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations **107**

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

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 **Adam F. Wagner** (M. D. or ~~Ch.D.~~)

Address **Greenville** Date signed **7-24-46**

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

AUG 13 1957

OCT 28 1957

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.....

*Coder Lomual Hoone*

....., Registered Apprentice No.....

working under my personal supervision.

Signed *William Coder*

Licensed Embalmer No. *3723*

P. O. Address *Piedmont, 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.