

No. 2
-12-45
-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1730
Registrar's No. _____

FILED JAN 29 1947

Registration District No. 12

Primary Registration District No. 5696

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

1. PLACE OF DEATH:

(a) County Livingston

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

(c) Name of hospital or institution:
10 Miles S.E. Jamesport, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
4 1/2 Years (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Charles Oreon Wilson

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: October 13 1915
(Month) (Day) (Year)

8. AGE: Years 31 Months 3 Days 5
If less than one day hr. _____ min. _____

9. Birthplace: Iola Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Farm

MOTHER FATHER

12. Name Clyde Wilson

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

14. Maiden name Cora Briggs

15. Birthplace Unknown Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Clyde Wilson

(b) Address Gallatin, Missouri

17. (a) Burial (b) Date thereof 1-20-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clear Creek Cemetery

18. (a) Signature of funeral director Hope Funeral Home

(b) Address Gallatin, Missouri

19. (a) 2-12-47 (b) Francis B. Neill
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town "Rural" Jackson Township
(If outside city or town limits, write "RURAL")

(d) Street No. 11 Miles S.E. Jamesport, Mo
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18
year 1947 hour About 5 minute P. M.

21. I hereby certify that I viewed the deceased after death
_____ 19____, to _____ 19____;

that I last saw h_____ alive on _____ 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death: Third Degree Burns

Due to Possible Carbon Monoxide

Due to Poisoning

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy S.H.P.
Car left roadway burst into flames

22. If death was due to external causes, fit in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Jan 18, 1947

(c) Where did injury occur? Rural Livingston Co. Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Public Highway

While at work? No (e) Means of injury Fire

23. Signature Le Muel - Livingston County, Mo

Address Chillicothe, Mo Date signed Jan 20, 1947

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

Savity

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.....

L. O. Richesson

..... Licensed Embalmer No. *3307*

..... P. O. Address *Gallatin, N.M.*

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. 137

Primary Registration District No. 5696

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town _____
(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 _____
years, months or days)

3. (a) PRINT FULL NAME Charles D. Wilson

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased Oct. 13 1901
(Month) (Day) (Year)

8. AGE: Years 31 Months 3 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) Kansas

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) Feb-12/47 (b) Francis B. Neil
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
 year 1947 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 _____

Duration _____

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

S-1730