

FILED MAY 2 1947

Registration District No. 176

Primary Registration District No. 5-63-6

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Lawrenceburg
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bank
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Lawrenceburg
(If outside city or town limits, write "RURAL")
(d) Street No. Bank
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

M. W. Wilkerson

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive years
7. Birth date of deceased 4 1892
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 4 If less than one day
hr. min.

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

10. Usual occupation farmer

11. Industry or business

12. Name Hueston Wilkerson
13. Birthplace Ark (City, town, or county) (State or foreign country)
14. Maiden name Molly Doherty
15. Birthplace Ark (City, town, or county) (State or foreign country)

16. (a) Informant Cecil Wilkerson
(b) Address Blau No

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 6 1947
(Month) (Day) (Year)
(c) Place: burial or cremation Johns Chapel

18. (a) Signature of funeral director Morris S. Leiman
(b) Address Ash Grove Mo

19. (a) (Date received local registrar) (b) W. S. Bussing (Registrar's signature) 15/3

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 4
year 1947 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from
..... 19..... to March 3 19.....
that I last saw him alive on March 3
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Due to arterio sclerosis

Other conditions (Include pregnancy within 3 months of death)
Major findings: 94%
Of operations.....
Of autopsy.....

Duration

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: 2
23. Signature A. F. Stapp (M.D. or other) Do
Address Caveau Mo Date signed 3/9/47

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

RECEIVED

District Health Officer No. 6;

District File Number 447-504

Date Filed APR 29 1947

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 Maude O. Morris

Licensed Embalmer No. 2055

P. O. Address Ark. Ave. 9105

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.