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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23164

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

FILED JUL 10 1947

Registration District No. 356

Primary Registration District No. 6209

Registrar's No. 112

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

7  
0  
0

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Rural Quincy  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Texas Co. Home 50  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 weeks  
(Specify whether  
In this community 2 yrs.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jefferson  
(c) City or town Rural  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES CLARENCE 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 Louise 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased Feb. 2 1877  
(Month) (Day) (Year)

8. AGE: Years 70 Months 3 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

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

MOTHER FATHER

12. Name J. W. Wilson  
13. Birthplace Iowa (City, town, or county) (State or foreign country)  
14. Maiden name Agatha White  
15. Birthplace Iowa (City, town, or county) (State or foreign country)

16. (a) Informant J. W. Wilson

(b) Address Solo Mo

17. (a) Removed (b) Date thereof June 12-49  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walden

18. (a) Signature of funeral director Rayford V. Elliott

(b) Address Houston Mo

19. (a) June 18-47 (b) Myrtle Craig  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11  
year 1947 hour 8 minute 9 M.  
21. I hereby certify that I attended the deceased from June 8  
1947 to June 11 1947  
that I last saw h. in alive on June 11  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration \_\_\_\_\_  
Due to Parkinson's disease  
(Paralysis agitans)  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: 107  
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? 0  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature G. T. Hoach (M. D. or other) M.D.  
Address Houston Date signed 6-13-47

RECEIVED

District Health Officer No. 5,

District File Number... 747351

Date Filed 7-8-47

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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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, 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.