

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 19, 1947  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 33

Registration District No. 240 Primary Registration District No. 6152

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

1. PLACE OF DEATH  
(a) County Stoddard  
(b) City or town 8 miles south west Bernie  
(c) Name of hospital or institution: Liberty 3  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM FRANKLIN WILSON  
3. (b) If veteran, name war NO 3. (c) Social Security No. X

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 \_\_\_\_\_

7. Birth date of deceased July 23 1879  
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

MOTHER FATHER  
12. Name Henry Wilson  
13. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name unknown  
15. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joe W. Jite head  
(b) Address Campbell, Route 1

17. (a) Rural (b) Date thereof Dec 3 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stacy Camp Bern

18. (a) Signature of funeral director Robert E. Deuss  
(b) Address Bernie Mo

19. (a) 12-10-47 (b) Lettie J. Jite  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Stoddard  
(c) City or town near Bernie  
(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 X

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec day 1  
year 1947 hour 10 minute A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, 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 accidental drowning  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 10/16  
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) accident  
(b) Date of occurrence Dec. 1, 1947  
(c) Where did injury occur? near Bernie Stoddard, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in about home, on farm, in industrial place, in public place?  
ditch on public road  
While at work? no (Specify type of place) (e) Means of injury drowning  
23. Signature Letty Jite (M.D. or other) Letty Jite  
Address Dexter, Mo. Date signed 12-1-47

RECEIVED

District Health Office No. 2,

District File Number 1247-1598

Date Filed 12-15-47

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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.....

*J. S. Schuman*  
Licensed Embalmer No. 4086

P. O. Address Malden

**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.**