

FILED FEB 21 1949

# THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

5728

State File No. ....

|                                                                                                                                                                                                                                                    |  |                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. ....                                                                                                                                                                                                                                     |  | REG. DIST. NO. <u>274</u>                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                          | PRIMARY REG. DIST. NO. <u>3052</u> Registrar's No. <u>57</u>                                                |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Pettis</u>                                                                                                                                                                                                       |  |                                                                                                                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>                                                                                                                                                                                                                                                                                                     |                                                                                                             |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u>                                                                                                                                                        |  | c. LENGTH OF STAY (in this place) <u>1 YEAR</u>                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                          | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DRESDEN (RURAL) DRESDEN</u> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2101 S. Washington</u>                                                                                                                                                                                  |  |                                                                                                                                 | d. STREET ADDRESS (If rural, give location) <u>/</u>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                             |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>John</u> b. (Middle) <u>C. REGG</u> c. (Last) <u>Wilson</u>                                                                                                                                |  |                                                                                                                                 | 4. DATE OF DEATH (Month) (Day) (Year) <u>2-11-1949</u>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                             |  |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                    |  | 6. COLOR OR RACE <u>W</u>                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>                                       |  |
| 8. DATE OF BIRTH <u>1-22-1856</u>                                                                                                                                                                                                                  |  | 9. AGE (In years last birthday) <u>93</u>                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10. IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> Hours <u></u> Min. <u></u>                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>                                                                                                                                          |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u>                                                   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                                                                                                                                                                                         |  | 13a. FATHER'S NAME <u>BERRY J. Wilson</u>                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 13b. MOTHER'S MAIDEN NAME <u>KATHARINE REES</u>                                                             |  |
| 14. NAME OF HUSBAND OR WIFE <u>MILDRED GLASCOCK</u>                                                                                                                                                                                                |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)              |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 16. SOCIAL SECURITY NO. <u>None</u>                                                                         |  |
| 17. INFORMANT'S SIGNATURE OR NAME <u>C. C. Whitehead</u>                                                                                                                                                                                           |  | ADDRESS <u>Houstonia, Mo.</u>                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                    |  |                                                                                                                                 | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arterio Sclerosis</u><br>DUE TO (c) <u>/</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                                                                             |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                             |  | 19b. MAJOR FINDINGS OF OPERATION <u>no op</u>                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)                                                                                                                                                                                                           |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                                                             |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.                                                                                                                                                                                                 |  | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21f. HOW DID INJURY OCCUR?                                                                                  |  |
| 22. I hereby certify that I attended the deceased from <u>2-6-1949</u> , to <u>2-11-1949</u> , that I last saw the deceased alive on <u>2-10-1949</u> , and that death occurred at <u>11 A. m.</u> , from the causes and on the date stated above. |  |                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                             |  |
| 23a. SIGNATURE (Degree or title) <u>Edward E. Moore M.D.</u>                                                                                                                                                                                       |  | 23b. ADDRESS <u>111 W. 4th Sedalia, Mo.</u>                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 23c. DATE SIGNED <u>2-12-49</u>                                                                             |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                            |  | 24b. DATE <u>2-14-1949</u>                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 24c. NAME OF CEMETERY OR CREMATORY <u>DRESDEN</u>                                                           |  |
| 24d. LOCATION (City, town, or county) (State) <u>DRESDEN Mo</u>                                                                                                                                                                                    |  | 24e. FUNERAL DIRECTOR'S SIGNATURE <u>Paul M. Moore</u>                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                          | ADDRESS <u>Ab. Monte Mo</u>                                                                                 |  |
| DATE REC'D BY LOCAL REG. <u>2-12-49</u>                                                                                                                                                                                                            |  | REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                          | 25. (Licensed Embalmer's Statement on Reverse Side)                                                         |  |

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 2-18-49

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.....

Student Embalmer No. ....

working under my personal supervision.

Signed Paul M. Moore

Signed.....  
Student Embalmer

Licensed Embalmer No. 3923

P. O. Address La Monte 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.