

FILED MAY 31 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 4006 State File No. 14736

BIRTH NO. _____ REG. DIST. NO. 2 PRIMARY REG. DIST. NO. 5013- Registrar's No. 338

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fillmore		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fillmore	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Edith b. (Middle) PEARL c. (Last) Wilson			4. DATE OF DEATH (Month) (Day) (Year) 5-17-1949			
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 10-15-1881	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Days 7	IF UNDER 2 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Andrew Co Mo O		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME William White		13b. MOTHER'S MAIDEN NAME Nancy Walker		14. NAME OF HUSBAND OR WIFE Ben Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ben Wilson Fillmore Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Circulatory Failure!		7 1/2 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Glomerulonephritis (Chronic) DUE TO (c) Essential Hypertension		Several years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Hypertrophic Pathitis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 592X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT 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 1/10, 1949, to 5/17, 1949, that I last saw the deceased alive on 5/17, 1949, and that death occurred at 2:40 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ernest B. Conrad D.O.	23b. ADDRESS Fillmore, Mo.	23c. DATE SIGNED 5/19/49
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5-19-1949	24c. NAME OF CEMETERY OR CREMATORY Fillmore
24d. LOCATION (City, town, or county) (State) Fillmore Mo		

DATE REC'D BY LOCAL REG. 5/18/49	REGISTRAR'S SIGNATURE William Sparker	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Breit Funeral Home SAVANNAH MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 28 1949

7627

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.

Student
Student Embalmer

Signed *E. C. Breit*

Licensed Embalmer No. *2650*

P. O. Address *Swanton, 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.