

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17818

State File No. 4107

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place) 2 mos		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rolla					
d. FULL NAME OF HOSPITAL OR INSTITUTION Frisco Hospital				d. STREET ADDRESS (If rural, give location) 103 N-St					
3. NAME OF DECEASED (Type or Print): a. (First) Joda b. (Middle) R c. (Last) Wilson			4. DATE OF DEATH 5-6-1949						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 1-22-1884			
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Leslie Arkansas			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Peter Wilson		13b. MOTHER'S MAIDEN NAME Anne Parker		14. NAME OF HUSBAND OR WIFE Agnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Judy Wilson		ADDRESS 6385 Smiley St.			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) Rolla (STATE) Mo					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 581A					
22. I hereby certify that I attended the deceased from May 1, 1949 , to May 6, 1949 , that I last saw the deceased alive on May 6, 1949 , and that death occurred at 3:40 m., from the causes and on the date stated above.									
23a. SIGNATURE John Paine Rohlf (Degree or title) M.D.				23b. ADDRESS Frisco Hospital		23c. DATE SIGNED 5-6-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-6-49		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Rolla Mo			
DATE REC'D BY LOCAL REGISTRY MAY 7 1949		REGISTRAR'S SIGNATURE J B Lasater		25. FUNERAL DIRECTOR Rowland Mortuary Service 4104 Manchester Ave.					

(Licensed Embalmer's Statement on Reverse Side)

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

N.R.

207A

MAY 31 1949

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 Van M. Dijkman

Licensed Embalmer No. 4343

P. O. Address Stennis 10 MD

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.