

FILED DEC 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36954

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1025-6

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY OR TOWN <u>SPRINGFIELD</u>	c. LENGTH OF STAY (in this place) <u>1</u> <u>4 1/2 MONTHS</u>	c. CITY OR TOWN <u>SPRINGFIELD</u> <u>RURAL - N. CAMPBELL</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1314 NORTH BROWN</u>		d. STREET ADDRESS (If rural, give location) <u>1314 NORTH BROWN</u>	

3. NAME OF DECEASED (Type or Print) <u>EZEKIEL</u>	a. (First) _____ b. (Middle) <u>✓</u> c. (Last) <u>WILSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11 23 1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2-3-1875</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
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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 _____	11. BIRTHPLACE (State or foreign country) <u>STONE CO. MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>JOHN WILSON</u>	13b. MOTHER'S MAIDEN NAME <u>RUTH MAPLES</u>	14. NAME OF HUSBAND OR WIFE <u>KISSIE MAPLES WILSON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>N</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. KISSIE WILSON</u> ADDRESS <u>1314 N. BROWN SPRINGFIELD, MO</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2-3 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Probably gastric tumor with hemorrhage</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from Oct., 1949, to 23 Nov, 1949, that I last saw the deceased alive on 23 Nov, 1949, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dennis F. Khalil Jr. MD</u> (Degree or title)	23b. ADDRESS <u>1630 N. Jefferson Ave</u>	23c. DATE SIGNED <u>26 Nov 49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>11-26-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WRIGHTS CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>CHRISTIAN CO. MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>11-29-49</u>	REGISTRAR'S SIGNATURE <u>W. L. H. Shaw</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Dean Harris</u> ADDRESS <u>Cleves Mo.</u>
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(Licenses Embalmer's Statement on Reverse Side)

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

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 John Dean Harris

Signed _____
Student Embalmer

Licensed Embalmer No. 4390

P. O. Address. Cleves, 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.