

STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 66

1. PLACE OF DEATH
 a. COUNTY Harrison 0411
 b. CITY (If outside corporate limits, write RURAL and give township) Bethany Mo
 c. LENGTH OF STAY (In this place) 60 days
 d. FULL NAME OF HOSPITAL OR INSTITUTION Bethany

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE Mo
 b. COUNTY Harrison
 c. CITY (If outside corporate limits, write RURAL and give township) Rural - Marion
 d. STREET ADDRESS (If rural, give location) 2 miles S.E. Cashville Mo

3. NAME OF DECEASED
 a. (First) William b. (Middle) W c. (Last) Wilson
 (Type or Print)

4. DATE OF DEATH (Month) (Day) (Year)
Aug. 7 - 51

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH May 30 - 1865

9. AGE (In years last birthday) 86 2 8 8
 of months Days Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer

10b. KIND OF BUSINESS OR INDUSTRY
Farmer

11. BIRTHPLACE (State or foreign country)
Waterloo Iowa

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME
David Wilson

13b. MOTHER'S MAIDEN NAME
Sarah Havens

14. NAME OF HUSBAND OR WIFE
Malinda Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
9

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS

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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) Generalized arteriosclerosis 10 yrs
 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
5 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
331X

20. AUTOPSY? YES NO

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)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from 8-2, 1951, to 8-7, 1951, that I last saw the deceased alive on 8-6, 1951, and that death occurred at 5:47 m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title)
Leonard R. Lee M.D.

23b. ADDRESS
Bethany Mo

23c. DATE SIGNED
8-10-51

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE
Aug-10-51

24c. NAME OF CEMETERY OR CREMATORY
Hidgeway Cemetery

24d. LOCATION (City, town, or county) (State)
1 mi. S.W. Hidgeway Mo

DATE REC'D BY LOCAL REG.
Aug 10

REGISTRAR'S SIGNATURE
Edith Cornelius Dep

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Robert R. Boggs Hidgeway Mo

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



SEP 18 1951

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

Robert R. Baggett

Licensed Embalmer No. *3576*

P. O. Address

Ridgeway m

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.