No. 300
10.48

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

FILED MAY 18 1953

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19101

BIRTH NO. 1243133 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 167

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1. PLACE OF DEATH
a. COUNTY St. Francois
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonne Terre
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonne Terre Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Francois
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elvins
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) LAWRENCE
b. (Middle) CLARENCE
c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year) May 7, 1953

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH May 6, 1953
9. AGE (In years last birthday) — If under 1 year: Months — Days 1 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) Bonne Terre, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Clarence E. Wilson
13b. MOTHER'S MAIDEN NAME Norma Moss
14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Mrs. William Moss — **ADDRESS** Elvins, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suspected cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) prolonged labor

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 7610
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) m.
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* May 6, 1953, *to* May 7, 1953, *that I last saw the deceased alive on* May 7, 1953, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Byron W. Taylor MD (Degree or title)
23b. ADDRESS Flat River, Mo
23c. DATE SIGNED 5-10-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE May 9, 1953
24c. NAME OF CEMETERY OR CREMATORY Bismarck Masonic
24d. LOCATION (City, town, or county) (State) Bismarck, Mo

DATE REC'D BY LOCAL REG. May 10, 1953
REGISTRAR'S SIGNATURE Esther Rudloff
25. FUNERAL DIRECTOR'S SIGNATURE SPARKS F. HOME **ADDRESS** Flat River, Mo

(Licensed Embalmer's Statement on Reverse Side)

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 Murphy L Sparks

Licensed Embalmer No. 4356

P. O. Address Flat Ave Na

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.