

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **30928**

No. 300  
10-48

**FILED OCT 7<sup>th</sup> 1953**

BIRTH NO. _____		REG. DIST. NO. <b>1</b>	PRIMARY REG. DIST. NO. <b>3000</b>	Registrar's No. <b>315</b>
<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).		
a. COUNTY <b>Adair</b>		a. STATE <b>Missouri</b> b. COUNTY <b>Sullivan</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kirksville</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Green City</b>		
c. LENGTH OF STAY (In this place) <b>6 days</b>		d. STREET ADDRESS (If rural, give location) <b>No street address</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Grim-Smith Memorial Hospital</b>				
<b>3. NAME OF DECEASED</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
a. (First) <b>George</b>			b. (Middle) <b>Pearl</b>	
c. (Last) <b>Wilson</b>			<b>Sept. 25 1953</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>
<b>8. DATE OF BIRTH</b> <b>January 28, 1873</b>		<b>9. AGE</b> (In years last birthday) <b>80</b>		If UNDER 1 YEAR: Months _____ Days _____ Hours _____ Mins _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Kentucky</b>
<b>13a. FATHER'S NAME</b> <b>Christopher Wilson</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Jane Payne</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Queen Wilson</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Queen Wilson, Green City, Mo</b>
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Carcinoma of Rectosigmoid</b>		<b>1 yr</b>
		<b>ANTECEDENT CAUSES</b>		
		DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		
		DUE TO (c) _____		
		<b>II. OTHER SIGNIFICANT CONDITIONS:</b>		
		Conditions contributing to the death but not related to the disease or condition causing death. <b>154 X</b>		
<b>19a. DATE OF OPERATION</b> <b>9/21/53</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Obstruction rectosigmoid due to annular Ca</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min)		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>
<b>22. I hereby certify that I attended the deceased from <u>9/19</u>, 19<u>53</u>, to <u>9/25</u>, 19<u>53</u>, that I last saw the deceased alive on <u>Sept 24</u>, 19<u>53</u>, and that death occurred at <u>12:58 A.m.</u>, from the causes and on the date stated above.</b>				
<b>23a. SIGNATURE</b> (Degree or title) <b>George E. Grim, MD</b>		<b>23b. ADDRESS</b> <b>Kirksville, Missouri</b>		<b>23c. DATE SIGNED</b> <b>9/30/53</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24b. DATE</b> <b>Sept. 27, 1953</b>		<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Hawkeye Cemetery</b>
		<b>24d. LOCATION</b> (City, town, or county) (State) <b>Sullivan Co., Mo.</b>		
<b>DATE REC'D BY LOCAL REG.</b> <b>10-5-53</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Kate Lambert</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Glenn E. Kenton, Green City, Mo.</b>
				<b>ADDRESS</b>

(Licensed 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.

Student \_\_\_\_\_  
Student Embalmer

Signed Carl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green City, 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.