

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 27 1955

State File No. **18439**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **5507** Registrar's No. **14**

1. PLACE OF DEATH a. COUNTY HENRY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY HENRY	
b. CITY OR TOWN DAVIS TWP.		c. CITY OR TOWN DAVIS TWP	
c. LENGTH OF STAY (in this place) 41 YRS		d. STREET ADDRESS (If rural, give location) FRHS CLINTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION AT HOME			

3. NAME OF DECEASED (Type or Print)	a. (First) PEARL	b. (Middle) M.	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) JUNE 19, 1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPT. 18, 1890	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 9 Days 1	IF ORDER IN RES. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) WEST VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME ROBERT D. NATHAN	13b. MOTHER'S MAIDEN NAME JANE PIERSON	14. NAME OF HUSBAND OR WIFE Arthur B. Wilson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Arthur B. Wilson, Clinton, Mo.	ADDRESS 7.5
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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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition & Debilitation		INTERVAL BETWEEN ONSET AND DEATH 6 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adenocarcinoma of transverse colon		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 153X			

19a. DATE OF OPERATION 10-20-54	19b. MAJOR FINDINGS OF OPERATION cancer of colon	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) Clinton, Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **10-17-54** to **6-19-55**, 19____, that I last saw the deceased alive on **6-19-55**, 19____, and that death occurred at **11:50 PM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. C. Sunderwith MD	23b. ADDRESS Clinton, Mo.	23c. DATE SIGNED 6-20-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE June 21, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Hope Well Cemetery, Mountain, Mo.	24d. LOCATION (City, town, or county) (State) Clinton, Mo.
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DATE REC'D BY LOCAL REG. 6-20-55	REGISTRAR'S SIGNATURE Florence Adair	25. FUNERAL DIRECTOR'S SIGNATURE H. A. Vaussant, Clinton, Mo.	ADDRESS _____
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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

H. L. Vassant

Licensed Embalmer No.

3779

P. O. Address

Clinton, 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.