No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

JUN 23 1952

State File No. 19678

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 217

1. PLACE OF DEATH
a. COUNTY: Callaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fulton
c. LENGTH OF STAY (In this place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Missouri
b. COUNTY: Pike 1921
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Louisiana 1
d. STREET ADDRESS (If rural, give location): 719 Jackson St.

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) c. (Last) Wilson
4. DATE OF DEATH (Month) (Day) (Year): June 20 1952
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: Mar. 4, 1874
9. AGE (Last birthday): 78 IF UNDER 1 YEAR: Months 3 Days 16 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Common Labor
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Indiana 1
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: William Wilson
13b. MOTHER'S MAIDEN NAME: Amanda Mosier
14. NAME OF HUSBAND OR WIFE: Frieda Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): DK (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: DK
17. INFORMANT'S SIGNATURE OR NAME: Hospital Records ADDRESS: Fulton Mo

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-renal disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4-4-2X
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* June 3, 1952, *to* June 20, 1952, *that I last saw the deceased alive on* June 19, 1952, *and that death occurred at* 4:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. C. Caldwell MD (Degree or title) By Hanks
23b. ADDRESS: State Hosp. Fulton Mo
23c. DATE SIGNED: 6/20/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/22/52
24c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery
24d. LOCATION (City, town, or county) (State): Louisiana Mo.

DATE REC'D BY LOCAL REG.: June 20-1952
REGISTRAR'S SIGNATURE: Maretta Lawrence 426
25. FUNERAL DIRECTOR'S SIGNATURE: Geo Maynard ADDRESS: Louisiana 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 Geo Wagner

Licensed Embalmer No. 3773

P. O. Address Louisiana Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.