WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Jasper

Township or Village Webb City or City Jasper Co Tuberculosis Hospital (No. ..... St.; ..... Ward)

Registration District No. 417 — File No. 25343

Primary Registration District No. 3021 — Registered No. 142

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry Wilkerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Divorced

6 DATE OF BIRTH: Aug (Month) 4 (Day) 1853 (Year)

7 AGE: 66 yrs. X mos. 17 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Miner 23 P
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Morgan Co Ill

PARENTS

10 NAME OF FATHER: Francis Wilkerson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Kent

12 MAIDEN NAME OF MOTHER: Elizabeth Daniels

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Wilkerson

(Address) Tar River Okla

15 Filed Nov 1919 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 21 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 14, 1919, to Aug 21, 1919, that I last saw him alive on Aug 21, 1919, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

28 (Duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary): none (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Ratliff M. D.

8-22-1919 (Address) Webb City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death — yrs. 4 mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? unknown

Former or usual residence: Blendville, Mo

19 PLACE OF BURIAL OR REMOVAL: Oak Hill Cem Galena Ks. — DATE OF BURIAL: Aug 23, 1919

UNDERTAKER: Webb City Hud Co — ADDRESS: Webb City.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St., ... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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