

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

Do not use this space.

12752

1. PLACE OF DEATH

County..... Dallas
Township..... Buffalo
City..... Buffalo (No. 4147)

Registration District No.
Primary Registration District No. 241

File No.
Registered No. 286
St. Ward)

2. FULL NAME

John S. Wilson

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Missie Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/8/1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 11 27

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

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Sampson Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Gibbin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. C. L. Johnson
(Address) Stover, Mo.

15. FILED 4/10, 1928 Harvey Morrow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/5 1928

17. I HEREBY CERTIFY, That I attended deceased from 3 to 2, 1928, to 4/5, 1928 that I last saw him alive on 4/5, 1928, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10:10 16:30 Sensitivity
..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Chronic Bronchitis
..... (duration) 25 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) Frank A. Hudson, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 4/6 1928

20. UNDERTAKER C. E. South & Son ADDRESS Buffalo, Mo.

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.

4 1928

