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

Do not use this space.

File No. 18916

Registered No. 6

1929

1. PLACE OF DEATH

County: Nodaway. Registration District No. 626

Township: Independence Primary Registration District No. 5828

City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Hugh Mordica Wilson

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

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Katherine Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 25 - 1857

7. AGE: Years 72 Months 9 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Nodaway Co. Mo

PARENTS

10. NAME OF FATHER: John Wilson.

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

12. MAIDEN NAME OF MOTHER: Owens.

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

14. INFORMANT: Bert Wilson. (Address): Sheridan. Mo

15. FILED May 19 1929 Hiram Day MD REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 17 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1924 to May 17 1929 that I last saw him alive on May 17 1929, and that death occurred, on the date stated above, at 3 30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart

92A

690

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Paralysis

..... (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

O DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Signs

(Signed) John W. Nigh, M. D.

19 (Address) Sheridan Mo.

*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: Brethren Cemetery. DATE OF BURIAL: 5/19 1929

20. UNDERTAKER: Longt Byd. ADDRESS: Sheridan, 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.