

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

Do not use this space.

33601

**1. PLACE OF DEATH**  
 County Howell Registration District No. 3824  
 Township \_\_\_\_\_ Primary Registration District No. 4777  
 City West Plains, Mo. (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Harley G. Wilson  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

2 **MEDICAL CERTIFICATE OF DEATH**

**3. SEX** ma **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married

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

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) Sept 11-

**7. AGE** YEARS MONTHS DAYS **IF LESS than 1 day,** \_\_\_\_\_ hrs. **or** \_\_\_\_\_ min.  
44      1      2

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Painter, etc  
 (b) General nature of industry, business, or establishment in which employed (or employer) Furniture Dealer  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Missouri

**10. NAME OF FATHER** Greenbury Wilson

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo.

**12. MAIDEN NAME OF MOTHER** Don't know

**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Don't know

**INFORMANT** Mrs. H. G. Wilson  
 (Address) West Plains, Mo.

**FILED** 10-25-29 O.P.A. Heinrich  
 REGISTRAR

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) 10/25 1929

**17.** I HEREBY CERTIFY, That I attended deceased from 10-23, 1929, to 10-25, 1929 that I last saw him alive on 10-23, and that death occurred, on the date stated above, at 6:30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Coronary heart disease  
chronic myocarditis  
93C  
94B

**CONTRIBUTORY (SECONDARY)** 9010  
 (duration) yrs. mos. ds.

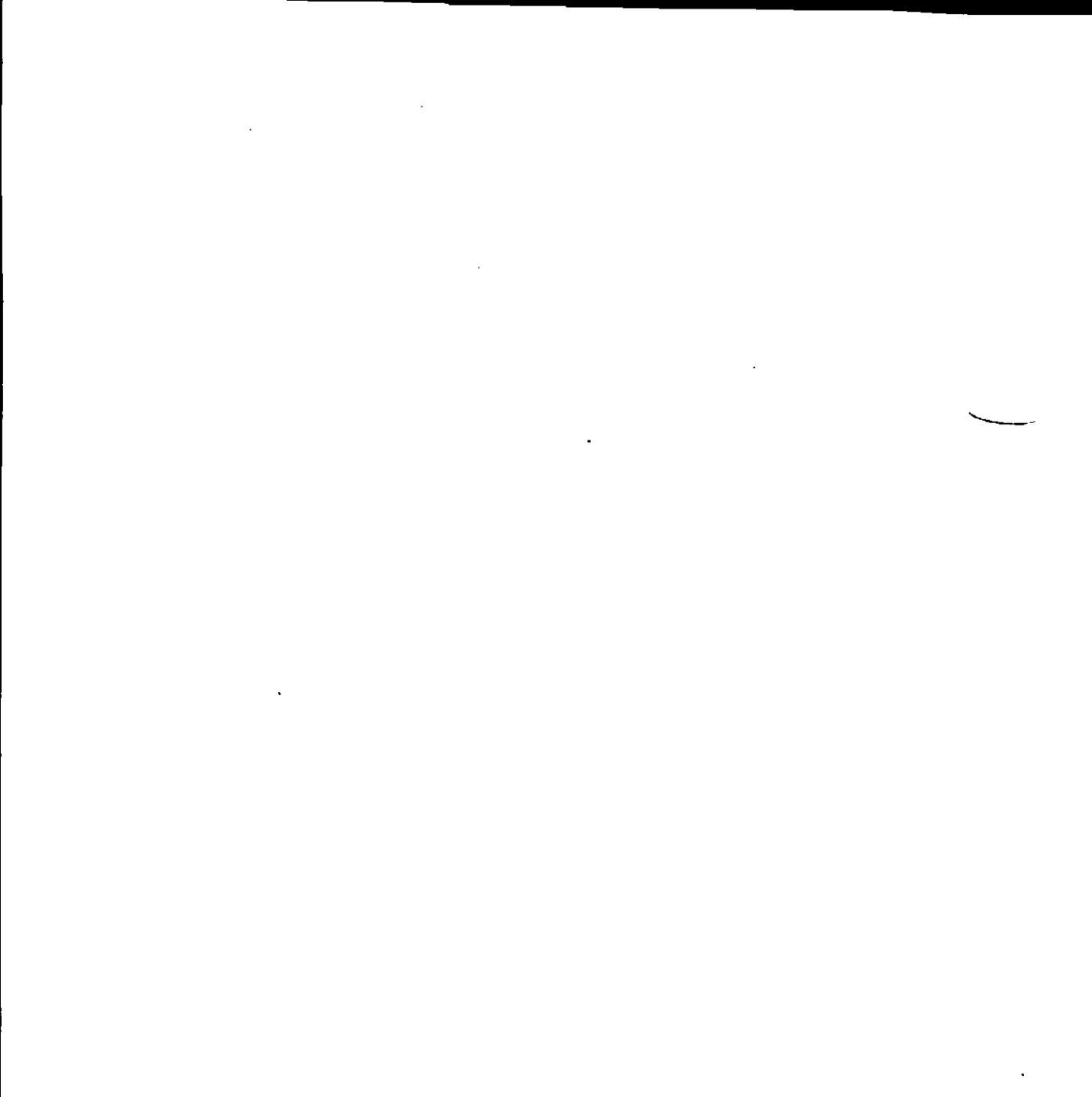
**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH. DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**  
 (Signed) E. Claude Bohner, M. D.  
10-25, 1929 (Address) West Plains, 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** Evergreen **DATE OF BURIAL** 10/25 1929

**20. UNDERTAKER** McFarland's **ADDRESS** West Plains, Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Howell

Registration District No. 384

File No. 100

Township West Plains

Primary Registration District No. 4227

Registered No. \_\_\_\_\_

City West Plains (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME**

Harley G. Wilson

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 11, 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
44 5 20

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) yrs. mos. ds.  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

PARENTS

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

**14.**

INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

**15.**

FILED 10 25 - 29 F. P. H. Heinrich REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) \_\_\_\_\_, 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

10953-S