

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

16385
Do not use this space.
Dr. W. H. Smith
216

39
5015

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. _____

Township _____

Primary Registration District No. 200

Registered No. _____

City Springfield

(No. Springfield Baptist Hosp.)

St. _____ Ward _____

2. FULL NAME

Dr. Fred Wilson

(a) Residence, No. Brumley Mrs St. _____ Ward _____

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 MEDICAL CERTIFICATE OF DEATH

3. SEX

M

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

Edna Wilson

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

Sept 6 - 1887

7. AGE

YEARS

MONTHS

DAYS

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

46

8

5

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

May 11 - 1934

22. I HEREBY CERTIFY, That I attended deceased from

May 1 1934, to May 11 1934

I last saw him alive on May 11 1934. Death is said

to have occurred on the date stated above, at 5 P. m.

The principal cause of death and related causes of importance were as follows:

Post-operative Pneumonia
12-6
1-27-34
1-3-34

Date of onset

Other contributory causes of importance:

Operation for cholecystectomy

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) Harris Smith M. D.

(Address) Springfield, Mo

12. BIRTHPLACE (CITY OR TOWN) Cauden Co
(STATE OR COUNTRY) Mo

FATHER

13. NAME M. H. Wilson

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

MOTHER

15. MAIDEN NAME Sallie Shipman

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

17. INFORMANT Mrs. Edna Wilson
(ADDRESS) Brumley Mrs

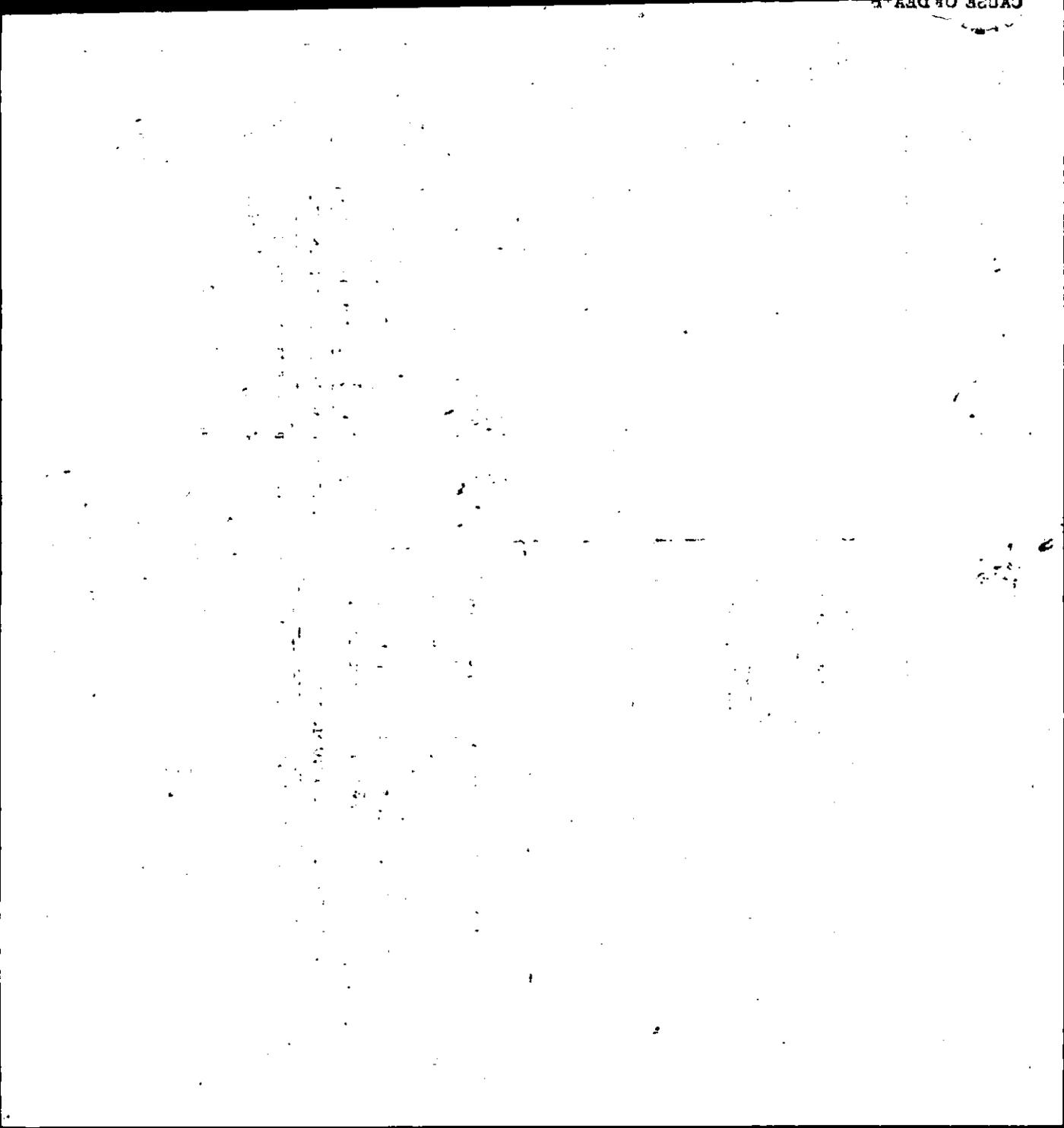
18. BURIAL, CREMATION, OR REMOVAL

PLACE Brumley DATE May 12 1934

19. UNDERTAKER Oliver P. Phipps
(ADDRESS) Springfield

20. FILED 5-10 1934 John W. ...
Registrar

Philip W. Langston



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township Springfield Primary Registration District No. 2001 Registered No. 216
 City Springfield (No. Spring Baptist Hosp) St. _____ Ward _____

2. FULL NAME

(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. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
46 8 5

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____ 19 _____

19. UNDERTAKER (ADDRESS)

20. FILED _____ 19 _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 11, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were, as follows: _____ Date of onset _____

Supplementary
 Cause of death: Aspiration - pneumonia
Bronchitis
 Contributory causes of importance: 10/70
Op. for cholecystectomy

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Walter Smith, M. D.
 (Address) Springfield Mo

SUPPLEMENTARY

Robert Longest
Registrar

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

PRINT IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD

5-16385

Green
Springfield

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

16385

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking in the death certificate.

Name: Fred Wilson
Died at Springfield Bapt. Hosp on May 11, 1954
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years 4 Months 8 Days 5
Sex: Male Color or race _____ Single, married, widowed or divorced: _____
Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, weaver, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Where deceased last worked at this occupation: Month _____ Year _____
Place (State or country) _____
Place of father (State or country) _____
Place of mother (State or country) _____

Principal cause of death: Post operative pneumonia (Operative cholecystectomy) Dangerous Gall bladder with gallstones

Other contributory causes of importance _____
Date of operation _____ Date of _____
Was test confirmed diagnosis? _____ Was there an autopsy? _____
Was death due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Number of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

Name of physician _____
Address of physician Travis Smith
Signature of Registrar J. J. Williams Jr

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 518
Primary Reg. Dist. No. 2001
Very truly yours,
E. T. McGaugh
Special Agent. M. W.

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