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.

I X14028

SEP 12 1939

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

28645
Do not use this space.

3
1

1. PLACE OF DEATH
(a) County Buchanan — Registration District No. 1
(b) Township — Primary Registration District No. — Registered No. 876
(c) City St. Joseph — (d) Street No. State Hospital #2, St. Joseph, Mo. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. 9 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 425 James Wilbur Wilson
(a) Residence, No. State Hospital #2 St. Laredo, Missouri.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Chloe Lina Wilson
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) ? 1866
7. AGE YEARS 73 MONTHS ? DAYS ? If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. carpenter
9. Industry or business in which work was done, as 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) ? 9

FATHER
13. NAME 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no information

17. INFORMANT (ADDRESS) Mrs. Chloe L. Wilson Laredo, Mo
18. ~~BURIAL, CREMATION,~~ OR REMOVAL
PLACE Laredo, Mo. DATE August 27, 1939
19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer (ADDRESS) 1302 Faraon St., St. Joseph, Mo.
20. FILED Aug 27 1939 H. J. Nestlebush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 27, 1939
22. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1939, to Aug 27, 1939
I last saw him alive on ....., 1939. Death is said to have occurred on the date stated above, at 4-10 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis with cerebral hem. (5 years prev)	
82-W	
Other contributory causes of importance: myocardosis	?

Name of operation none Date of —
What test confirmed diagnosis? Clinical Was there an autopsy? no

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? no
If so, specify
(Signed) I. T. O'Dell, M. D.
(Address) St Joseph

Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, Yes

, or by ,

Registered Apprentice No., working under my personal supervision.

Signed John C Anderson

Licensed Embalmer No. Mo. #4056

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.