

Registration District No. 774

Primary Registration District No. 4465

Registrar's No. 900

1. PLACE OF DEATH:

(a) County ST. FRANCIS 2  
(b) City or town FLAT RIVER  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME CHARLES EDWARD WILKINSON 4219

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife ETTIE WILKINSON 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased DEC. 27 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>10</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation MACHINES

11. Industry or business \_\_\_\_\_

12. Name JOSEPH WILKINSON

13. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

14. Maiden name NILLE ASHAI

15. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Charles Edward Wilkinson

(b) Address FLAT RIVER MISSOURI

17. (a) BURIAL (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WOOD LAWN

18. (a) Signature of funeral director C. J. Boyer

(b) Address DELLAGE MISSOURI 647

19. (a) 10/25/39 (b) C. J. Boyer M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Flat River Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 24  
year 1939 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Oct 10, 1939, to Oct 24, 1939

that I last saw him alive on Oct 23, 1939

and that death occurred on the date and hour stated above.

Immediate cause of death Ventricular Fibrillation Duration \_\_\_\_\_

Due to myocardial vascular degeneration 9 mo severe glomerular nephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

28. Signature H. G. ... (M. D. or other) \_\_\_\_\_

Address DeLage Mo Date signed 10-26-39

WHILE FILLING IN—USE UNFADING BLACK INK—MAKE 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.

922

201  
201  
201

**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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Burlin J. Bajus

Licensed Embalmer No. 3660

P. O. Address Hustoge, 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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

37065-  
Do not use this space.

1. PLACE OF DEATH *St. Francis*  
 (a) County *St. Francis* Registration District No. *774*  
 (b) Township *Flat River* Primary Registration District No. *4465*  
 (c) City *Flat River* (d) Street No. \_\_\_\_\_ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Charles Edward Wilkinson*  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>50</i>	<i>10</i>	<i>27</i>	

OCCUPATION

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

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) \_\_\_\_\_

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. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 24* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the day specified above, at \_\_\_\_\_ m.

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

*ventricular and auricular fibrillation*

*total Regurgitation of the coronary-arterial system*

Other contributory causes of importance: *acute*

Date of onset \_\_\_\_\_

*92 W 12-13-39*

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) *H. E. Grebe*, M. D.  
 (Address) *Desloge, Mo.*

SUPPLEMENT

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

Local Registrar.

