

Registration District No. 1244

Primary Registration District No. 1244

Registrar's No. _____

1. PLACE OF DEATH

(a) County Iron Mountain Mo
(b) City or town Same
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days 44 yrs

3. (a) PRINT FULL NAME MAHAHAJ WILSON 425

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Scott Wilson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 14 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months Sept 1910 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Iron Mountain Mo
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business _____

12. Name Reggie Sarah

13. Birthplace _____

14. Maiden name Reggie Phans

15. Birthplace _____

16. (a) Informant's own signature _____

(b) Address Elvins Mo

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director [Signature]

(b) Address Elvins Mo

19. (a) (Date received local registrar) _____ (b) (Registrar's signature) [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Iron

(c) City or town Elvins 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 Feb day 2
year 1940 hour 1:00 minute _____ M.

21. I hereby certify that I attended the deceased from Nov 1st 1939 to Feb 1st 1940 that I last saw her alive on Jan 27th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial Duration _____

Due to _____

Due to A Complicating chronic interstitial nephritis

Other conditions Arteriosclerosis & Hypertension
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature E. E. Hite (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A LEGIBLE 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.

FILED FEB 7 1940

01-1-1914

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3618**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **771**

Primary Registration District No. **6017**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St. Francois
(b) City or town Iron Rural
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

Martha J. Wilson

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years 79 Months 3 Days 17

If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name unknown

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

16. (a) Informant _____

(b) Address _____

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 2-4-40
(Month) (Day) (Year)

(c) Place: burial or cremation Iron Mountain Mo
Whole & Son

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-4-40
(Date received local registrar)

(b) F. H. Gale, M.D.
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 Feb day 2
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature E. E. Whiteside (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

