

APR 23 1940

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 69

1. PLACE OF DEATH:

- (a) County Randolph
 (b) City or town Moberly
 (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 Messiah WILSON 425

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

4. Sex Male 5. Color or race col 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Maggie Wilson 6. (c) Age of husband or wife if _____

7. Birth date of deceased March 17 1886
 (Month) (Day) (Year)

8. AGE: Years 54 Months - Days 9 If less than one day _____
 hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER
 { 12. Name Henry Wilson
 { 13. Birthplace MO
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Sarah Porter
 { 15. Birthplace MO
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Willie Hicks

- (b) Address 408 Dorsey

17. (a) Burial (b) Date thereof 3/30/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Robert A. Carr

- (b) Address 417 1/2 Moberly Mo.

19. (a) MAR 27 40 (b) Paul Williamson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County Randolph

- (c) City or town Moberly
 (If outside city or town limits, write "RURAL")

- (d) Street No. 408 Dorsey St
 (If rural, give location)

- (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26th
 year 1940 hour 8:10 minute 0 M.

21. I hereby certify that I attended the deceased from March 25 to March 26 / 1940
 that I last saw him alive on March 26 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 day

Due to _____

Due to _____

Other conditions Previous stroke was 2 1/2 yrs ago
 (Include pregnancy within 3 months of death)
arteriosclerosis

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?
Yes

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

23. Signature [Signature] (M. D. or _____)

Address Moberly Mo Date signed 3/27/40

RECEIVED

District Health Officer No. 10

District File Number 4-40-882

Date Filed APR 15 1940

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.....

Robert A. Carr

Licensed Embalmer No.....

3190

P. O. Address.....

notedly 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12157

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735-

Primary Registration District No. 3034

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(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 Meshaeh Wilton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race col

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

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 34 Months - Days 9 If less than one day _____ min.

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

10. Usual occupation None - was blind

11. Industry or business pensioner

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) M.S. 27-40 (Date received local registrar) (b) Leah Williams (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 mech day 26 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 L. E. Hyber (M. D. or other) _____

Address Moberly, Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1940

S-12151