DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18073

Registration District No. 12d Primary Registration District No. 3009 Registrar's No. 176

1. PLACE OF DEATH
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Southeast Mo Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution all of life (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Cape Girardeau
(c) City or town: Rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Near Oak Ridge, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: BERNICE JEAN WILLS 420
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: Female
5. Color or race: white
6. (a) Single, widowed, married, divorced:
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: April (Month) 28 (Day) 1940 (Year)

8. AGE: Years | Months | Days: 19 | If less than one day ____ hr. ____ min.

9. Birthplace: Cape Girardeau (City, town, or county) Mo (State or foreign country)

10. Usual occupation: ✓

11. Industry or business: —

FATHER
12. Name: Ancil Wills
13. Birthplace: Oak Ridge (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Maynie Walker
15. Birthplace: Oak Ridge (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature: Ancil J. Wills
(b) Address: Oak Ridge, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 18 (Month) (Day) (Year)
(c) Place: burial or cremation: New Salem

18. (a) Signature of funeral director: R. Miller
(b) Address: Jackson Mo

19. (a) 5-17-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-17 day 17 year 1940 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from 4-28, 1940, to 5-17, 1940 that I last saw her alive on 5-16, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: peritonitis	
Due to: pyloric obstruction - followed by operation	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 157 F	

Major findings:
Of operations: Thickened pyloric ring - breaking down of operation
Of autopsy: Four duodenal perforation - 1 pinpoint & large ulceration

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) (e) Means of injury: ✓

23. Signature: Alberom Estes (M. D. or other)
Address: Jackson, Mo Date signed: 5-17-40

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address.....

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

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