

AUG 23 1946
 WRITE PLAINLY—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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 836 Primary Registration District No. 6100 Registrar's No. 31

1. PLACE OF DEATH:
 (a) County Stoddard
 (b) City or town Parma
 (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

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Stoddard
 (c) City or town Parma Rt 1
 (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.

3. (a) PRINT FULL NAME Pauline ~~Wilson~~ ^{Richmond}
 3. (c) Social Security No. _____
 3. (b) If veteran, name war L

4. Sex F 5. Color or race O 6. (a) Single, widowed, married, divorced S
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased June 4 1940
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation Domestic

11. Industry or business _____
 12. Name W. M. Wilson
 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Jennie May ~~Wilson~~
 15. Birthplace Ark
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature R. R. Richmond
 (b) Address Parma, Mo

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Pitman, Mo

18. (a) Signature of funeral director Laura Hopkins
 (b) Address _____

19. (a) 7-16-40 (b) _____
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 11
 year 1940 hour 2:42 minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
I did not see baby
I do not know what was wrong. Possible injury at delivery.
 Due to _____
 Due to Woman delivered the baby delivered
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____
 Of autopsy 2000
 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) (b) Means of injury _____
 23. Signature R. R. Richmond (M. D. or other) _____
 Address Parma, Mo Date signed 7/11/40

RECEIVED

District Health Officer No

District File Number 840-13

Date Filed 8/9/4

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.