

Registration District No. 944

Primary Registration District No. 5447-B

Registrar's No. 43

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield Jackson Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Strafford Route # 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
(Specify whether years, months or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Jackson Twp Strafford R.F.D. #1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 22<sup>nd</sup>  
year 1940 hour 1:50 minute A.M.

21. I hereby certify that I attended the deceased from Sept. 10, 1938, to Sept. 15, 1940  
that I last saw him alive on Sept. 15, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hodgkins Disease Duration 3 years

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

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

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

Major findings: \_\_\_\_\_  
Of operations No  
Of autopsy No

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? 938  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature R. H. Foerit (M. D. or other) MD.  
Address Strafford Mo Date signed 9/23/40

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

3. (a) PRINT FULL NAME

BENJAMIN HARVEY WILSON

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Hulda Wilson

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased April (Month) 18 (Day) 1875 (Year)

8. AGE: Years 65 Months 5 Days 4 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace No Record Tennessee (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Farmer

12. Name William Wilson

13. Birthplace No Record Tennessee (City, town, or county) (State or foreign country)

14. Maiden name No Record

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

16. (a) Informant Ray Wilson

(b) Address 1519 N. Kansas Springfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Malineaux

18. (a) Signature of funeral director H. C. Thomas

(b) Address Springfield Mo

19. (a) 9-26-40 (Date received local registrar) (b) Harry Geier (Registrar's signature)

RECEIVED

Greene County Health Office,

County File Number 40-16-80

Date Filed 10/10/40

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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 *R. H. Christie*

Licensed Embalmer No. 3681

P. O. Address Springfield, 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, fact should be so stated above.**