

13-40
17-39
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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38894**
Registral's No. **DEC 10 1940**

Registration District No. **411**

Primary Registration District No. **2002**

Registral's No. _____

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Johns Hospital**
(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 **Jasper**

(c) City or town **Joplin**
(If outside city or town limits, write "RURAL")

(d) Street No. **2220 Pearl**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Mary Wilson**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **6th**
year **1940** hour **3** minute **45A.** M.

4. Sex **Female** 5. Color or race **White**

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

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

7. Birth date of deceased **Nov. 28, 1891**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **8-24-** 19**40**, to **10-6** 19**40**, that I last saw her alive on **10-5** 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Fatigue.** Duration **24 hrs**

8. AGE: Years **48** Months **10** Days **8** If less than one day _____ hr. _____ min.

Due to **Uncontrollable Diabetes.**

9. Birthplace **Ft. Madison, Iowa**
(City, town, or county) (State or foreign country)

~~XXXX~~ **Surgical repair of huge ventral hernia.** 9-10-40

10. Usual occupation **At Home**

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

11. Industry or business _____

MOTHER FATHER { 12. Name **Peter Larson**

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

14. Maiden name **Unknown**

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

Major findings: **127B**

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **W. W. Wilson**

(b) Address **Montgomery City, Mo.**

22. If death was due to external causes, fill in the following:

17. (a) **Burial** (b) Date thereof **10-8-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(e) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Place: burial or cremation **Forest Park Cem.**

(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? **310**

18. (a) Signature of funeral director **Lanpher Mortuary**

(b) Address **Joplin, Mo.**

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

19. (a) **10-8-40** (b) **Ed D. James**
(Date received local registrar) (Registrar's signature)

23. Signature **Ed D. James** (M. D. or other) **!**
Address **Joplin Mo** Date signed **10-7-40**

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

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, fact should be so stated above.

11-29-40

This certificate was delayed in
Dr. DeTar's office, the attending
Physician.

Ed D. James, M. D.
Registrar

Mary Wilson

S-38894 1940