

S. No. 2  
4-13-40  
5-17-40  
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FILED JAN 6 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
JAN 6 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **42011**

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 335

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton Mo

(c) Name of hospital or institution: State Hosp #1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 mo 2 da  
(Specify whether years, months or days) 3

3. (a) PRENT FULL NAME Leslie Wilkerson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. DK

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

6. (b) Name of husband or wife Helen Wilkerson 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased Feb 22 1906  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

34 34 9 20 hr. min.

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

10. Usual occupation Laborer 0

11. Industry or business 0

12. Name George Wilkerson 0

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

14. Maiden name Susan Darby  
(City, town, or county) (State or foreign country)

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

16. (a) Informant State Hosp #1

(b) Address Fulton P.

17. (a) REMOVAL (b) Date thereof 12 16 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mexico Mo

18. (a) Signature of funeral director H. H. Koldy

(b) Address Mexico Mo

19. (a) Dec 14 1940 (b) R. N. Crews  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway

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

(d) Street No. 1008 E. Lafayette St  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12  
year 1940 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1/10, 1940, to 12/12, 1940  
that I last saw him alive on 12/12, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia 12/12/40  
Duration

Due to 34

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

Other conditions Asphyxia with Septic  
(Include pregnancy within 3 months of death) Mumps Encephalitis

Major findings: Mumps Encephalitis

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(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? no

23. Signature H. Flood (M. D. or other) no

Address State Hosp #1 Date signed 12/12/40

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

14  
2  
2

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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 *A. H. Reynolds*

Licensed Embalmer No. *3521*

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.**