S. No. 2
—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 14 1942

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 29651

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 239

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: A. S. O. Hospital O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Three days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Sullivan 105
(c) City or town Milan - Rural O (If outside city or town limits, write "RURAL")
(d) Street No. Route #1. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Robert W. Wilson
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White O
6. (a) Single, widowed, married, divorced Single O
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. (Month) 1 (Day) 1927 (Year).

8. AGE: Years 15 Months 7 Days 7 If less than one day hr. min.
9. Birthplace Milan (City, town, or county) Missouri (State or foreign country)
10. Usual occupation School boy
11. Industry or business —
FATHER
12. Name Oliver Wayne Wilson
13. Birthplace Milan, Mo. O (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Isabel Sloan
15. Birthplace Milan, Mo. O (City, town, or county) (State or foreign country)
16. (a) Informant O. W. Wilson
(b) Address Milan, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1942 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ St Mary's Cem. Milan, Mo.
18. (a) Signature of funeral director Schoene's
(b) Address Milan, Mo. (Frank D.)
19. (a) 9/10/42 (Date received local registrar) (b) Mrs. J. P. Wayne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 8 day 8th year 1942 hour 6th minute 47th A.M.
21. I hereby certify that I attended the deceased from Sept 5th, 1942 to Sept 8, 1942 that I last saw him alive on Sept 8th 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Spinal Cerebral Meningitis

Due to A Complication of Left frontal sinus infection —

Due to A mixed infection with Colon Bacillus predominating —

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations Drained sub periostial abscess over Left frontal area. —
Of autopsy

Duration 6

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? (Specify type of place)
While at work? (e) Means of injury 2
23. Signature C. L. Atteberry (~~M. D. or~~ other) DO
Address A S O Hospital - Kirksville Date signed Sept 8, 42

1077 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-18844
Date Filed OCT 12 1942

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 Frank D. Schoen

Licensed Embalmer No. 2016

P. O. Address Milan, Mi

**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.**