

FEB 9 1943  
Registration District No. 120

Primary Registration District No. 5444

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Rural Athens  
(If outside city or town limits, write "RURAL" and name of township)  
(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  
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME William Roger Wilson

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex Male 5. Color or Race white 5. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive, years

7. Birth date of deceased Jan. 16 1943  
(Month) (Day) (Year)

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

9. Birthplace Gentry County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER  
12. Name Herman Wilson  
13. Birthplace Gentry County Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Maxine Collier  
15. Birthplace Gentry County Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Herman Wilson  
(b) Address Albany, Mo.

17. (a) Burial (b) Date thereof 1/19/43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Grandview

18. (a) Signature of funeral director Albany, Mo.  
(b) Address

19. (a) 1/19/1943 (b) Herman R. DeBates  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18  
year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Jan. 16  
1943 to Jan. 18, 1943  
that I last saw him alive on Jan. 18, 1943  
and that death occurred on the date and hour stated above.  
Immediate cause of death Unknown Duration

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
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:  
(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) (e) Means of injury  
23. Signature G. J. Pray (M. D. or other)  
Address Albany, Mo. Date signed 1-19-43

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 me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Clifford Brooks

Licensed Embalmer No. 3329

P. O. Address Albany 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2201

Registration District No. 120

Primary Registration District No. 5444

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(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

3. (a) PRINT FULL NAME W<sup>M</sup> Roger Wilson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

{ 14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M.D. or other) \_\_\_\_\_  
Address Albany, Mo Date signed 3-1-46

Duration

2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

