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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7385

State File No. _____

FILED MAR 3 1943

Registration District No. 295

Primary Registration District No. 6015

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Salt Spring Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME David Harold Wilson

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

4. Sex Male 5. Color or race White 6. (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 November 17 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 1 22 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Kennie Wilson
13. Birthplace Chariton County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Lena Stein
15. Birthplace Vernon County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lena Stein Wilson

(b) Address Moberly, Missouri - RR #4

17. (a) burial (b) Date thereof 1/10/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntsville Cemetery

18. (a) Signature of funeral director Tom B. Patton

(b) Address Huntsville Ind

19. (a) 2-1-43 (b) Mrs. P. [unclear]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly, RR#4
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8
year 1943 hour 3:10 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan 8 1943 to Jan 8 1943
that I last saw him alive on Jan 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 3 days

Due to _____

Due to _____

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

Major findings:
Of operations none
Of autopsy none

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 P. Dreyer (M. D. or other) MD

Address Huntsville Ind Date signed 2/1/43

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

1029

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 342-405

Date Filed MAR 31 1943

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

Tom B. Patton

Licensed Embalmer No.

3914

P. O. Address:

Huntville

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. 7385

Registration District No. 295

Primary Registration District No. 6015

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph

(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME David Harold 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 m 17 19
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 17
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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 January year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death bronchial pneumonia Duration 3 days

Due to no complications

Due to _____

Other conditions none
(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 [Signature] (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

SECRET

CONFIDENTIAL

TOP SECRET

SECRET

CONFIDENTIAL

SECRET