

FILED SEP 8 1943
Registration District No. **275**

Primary Registration District No. **5942**

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

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rolla, Mo. (If outside city & 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 Clayborn Elmus Wilson.

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

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida Henretta Schaffer 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased May 7, 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 2 28 hr. _____ min.

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

10. Usual occupation Farming.

11. Industry or business

MOTHER FATHER { 12. Name James Wilson,
13. Birthplace Iowa (City, town, or county) (State or foreign country)
14. Maiden name Hannah Arnold,
15. Birthplace Iowa. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. E. Wilson,

(b) Address Rolla, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Rolla Cemetery

18. (a) Signature of funeral director Null & Son Funeral Home

(b) Address 508 West 8th St., Rolla Mo.

19. (a) Aug. 7, 1943 (Date received local registrar) James H. Hester (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Rolla, Hi. Way 63 South (If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 year.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5
year 1943 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from about 10 years
1933 to Aug 5 1943;
that I last saw him alive on Aug 10 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial regurgitation Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92 L

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? _____

23. Signature William McFarland (Specify type of place) (th) Means of injury _____
Address Rolla Mo. Date signed 8/7/43

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 275

Primary Registration District No. 5942

Registrar's No. 80

SEP

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

1. PLACE OF DEATH:
 (a) County Phelps
 (b) City or town Rolla 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)

3. (a) PRINT FULL NAME Clayborn Elmus 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 m
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 7 (Month) (Day) (Year)
 8. AGE: Years 70 Months 2 Days 12
(Less than one day _____ min.)

9. Birthplace Iowa
(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 aug 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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

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