

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37822

FILED DEC 6 1943 42  
Registration District No. 42

Primary Registration District No. 001-1000

Registrar's No. 1232

1. PLACE OF DEATH:

(a) County BUCHANAN  
(b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: MO METHO HOSPITAL  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CALDWELL  
(c) City or town BRECKENRIDGE 013  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_ 1

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month Nov 7 day  
year 1943 hour 3 minute 0 A.M.  
11. I hereby certify that I attended the deceased from Nov 1st 4:45pm  
1943 to Date of death, 19\_\_\_\_;  
that I last saw him alive on 11-6-43, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis Chronic  
Myocarditis - Duration 4 yrs.  
2 yrs.

Other conditions (Include pregnancy within 3 months of death)  
Strangulated femoral hernia  
1318

Major findings: Strangulated femoral hernia  
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 Paul Ingraw (M. D. or other) \_\_\_\_\_  
Address St Joseph, Mo Date signed 11-9-43

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

3. (a) PRINT FULL NAME DR. ALBERT ROSS WILSEY

3. (b) If veteran, name war WORLD WAR #1 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife HAZEL WILSEY 6. (c) Age of husband or wife if alive 48 years  
7. Birth date of deceased SEPT 21 1869 (Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 16 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace ST. FRANCESVILLE MO (City, town, or county) (State or foreign country)

10. Usual occupation PHYSICIAN & SURGEON

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

MOTHER { 12. Name HARVEY WILSEY  
13. Birthplace PENNA (City, town, or county) (State or foreign country)

14. Maiden name Mary Jane Scott  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Hazel F. Wilsey  
(b) Address Breckenridge Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 9 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director AT McNeil  
(b) Address Breckenridge Mo

19. (a) 11-9-43 (Date received local registrar) (b) Rae Herzog (Registrar's signature)

MAY 15 1945 MAY 24 1945

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.....

*T. J. McKelvey*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*T. J. McKelvey*

Licensed Embalmer No. 1570

P. O. Address.....

*Bree Kenridge*

**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.**