

FILED JUL 25 1944

Registration District No. 43

Primary Registration District No. 5135

Registrar's No. 230

12
7
3

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

1. PLACE OF DEATH

(a) County Butler

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

(c) Name of hospital or institution: Asheville
(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 Wesley C. Wilson

3. (b) If veteran, ✓ name war ✓

3. (c) Social Security No. 498-12-3147

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Lena Wilson 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased April 15 1887
(Month) (Day) (Year)

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

63 2 27 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Champ Wilson

13. Birthplace Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Melissa Adcock

15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elbert Ison

(b) Address Dublin Mo. Rural

17. (a) Burial (b) Date thereof July 14 - 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dublin Mo.

18. (a) Signature of funeral director Landers Funeral Home

(b) Address Campbell Mo

19. (a) 7-216-44 (b) Pelle Thune
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler

(c) City or town Dublin Rural
(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 July day 12 year 1944 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from July 9 1944, to July 12 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Gastric Hemorrhage

Due to Perforated Gastric Ule

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? ✓

23. Signature Scott Cook (Specify type of place) _____ (e) Means of injury _____ (M. D. or other)

Address Dublin Mo Date signed 7/14-44

Duration 2 weeks

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

AUG 18 1944

RECEIVED

District Health Office No. 2,

District File Number 744-971

Date Filed 7-20-44

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 E. W. Rader

Licensed Embalmer No. 2289

P. O. Address Campbell 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.