

FILED SEP 12 1944

Registration District No. **14**

Primary Registration District No. **3008**

14
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Callaway
 (b) City or town Trinidad
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Helen Ross #19
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution one 11-7-39 (Specify whether)

In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Callaway
 (c) City or town Jefferson City
 (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 _____

3. (a) PRINT FULL NAME Charles O. Wilson
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 18
 year 1944 hour 2 minute 0 M.
21. I hereby certify that I attended the deceased from 3-23-
1944 to 8-18-
1944
 that I last saw him alive on 8-18-
1944
 and that death occurred on the date and hour stated above.

4. Sex Male **5. Color or race** W
6. (a) Single, widowed, married, 3 divorced
(b) Name of husband or wife _____ **(c) Age of husband or wife if** _____
 alive _____ years
7. Birth date of deceased Aug - 14 - 1892
 (Month) (Day) (Year)

Immediate cause of death Pneumonia Duration _____
Embolic

8. AGE: Years 52 Months _____ Days 8 If less than one day _____ hr. _____ min.

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

9. Birthplace Mo _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation W

MOTHER FATHER
11. Industry or business _____
12. Name John Wilson
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name W
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

16. (a) Informant Record
 (b) Address _____
17. (a) Removal _____ (b) Date thereof 8-25-1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Wicksville Mo
18. (a) Signature of funeral director Wallace Funeral Home
 (b) Address Wicksville Mo
19. (a) 8-25-1944 (b) John M. ...
 (Date received local registrar) (Registrar's signature)

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? _____ (c) Means of injury _____
23. Signature T. E. ... (M. D. or other)
 Address Wicksville Mo Date signed 8/18/44

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

9-9-48

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: *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address. *Fulton 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.