

FILED MAR 1 1945

State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 131

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town Springfield  
(c) Name of hospital or institution: St. John's Hosp.  
(d) Length of stay: In hospital or institution 5 Days  
In this community 5 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Howall  
(c) City or town Route # 3 West Plains, Mo.  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? No. /

3. (a) PRINT FULL NAME James H. Wilson

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

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

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

7. Birth date of deceased April 28 1889

8. AGE:	Years	Months	Days	If less than one day
55	9	16		hr. min.

9. Birthplace Dora Mo. 9

10. Usual occupation Farmer

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

12. Name Tyler Wilson

13. Birthplace unkn Tenn. 1

14. Maiden name Sarah Bushong

15. Birthplace unkn Tenn. 1

16. (a) Informant Mrs. Maude Wilson

(b) Address Route # 3 West Plains, Mo 1

17. (a) Burial (b) Date thereof 2/15/45

(c) Place: burial or cremation West Plains, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 2-15-45 (b) S. W. Handley

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 14 year 1945 hour 11:00 minute a. M.

21. I hereby certify that I attended the deceased from Feb. 9, 1945 to Feb. 14, 1945; that I last saw h.r. alive on Feb. 14, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Anterior Myocardial Heart Disease 2 Mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) A 2 1/2

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 \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_ Address \_\_\_\_\_ Date signed 2/14/45

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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 *L. John Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield md*

**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.**