

S. No. 2
M-8-43
v. 5-17-39
X37823

33497

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 64 Primary Registration District No. 5242 Registrar's No. 59

1. PLACE OF DEATH:

(a) County Chariton Bee Branch Twp
(b) City or town Marceline Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton
(c) City or town Marceline Mo
(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 Blanche May Wilson

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Alza Wilson 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased March 24 1890
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 13 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name James Carpenter

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

14. Maiden name Mary McLaughlin

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

16. (a) Informant Mrs Bessie Foster

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Sept 9 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) 9-10-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1945 hour 5 minute 15 P.M.
21. I hereby certify that I attended the deceased from Mar 24 1942 to Sept 7 1945
that I last saw her alive on Sept 7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 8 hours
Due to Arteriosclerosis, Hypertension
Due to _____

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

Major findings:
Of operations 440
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? _____

(Specify type of place) _____
While at work? _____ (c) Means of injury _____
23. Signature John W. Gibson (M. D. or other) _____
Address Marceline Mo Date signed 9-8-45

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

21
0
0

1410

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-11-45

ew

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 Blanche Manglier

Licensed Embalmer No. 1909

P. O. Address Marseline M

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.