

FILED JAN 25 1946

State File No. _____

Registration District No. UPrimary Registration District No. 4023Registrar's No. 76

1. PLACE OF DEATH:

(a) County Barry
(b) City or town Exeter
(c) Name of hospital or institution: /
(If outside city or town limits, write "RURAL" and name of township)(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life _____ (Specify whether)
years, months or days)3. (a) PRINT NAME FULL NAME MARY JANE WILHELM3. (b) If veteran, name war -- 3. (c) Social Security No. --4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced W Y
6. (b) Name of husband or wife A.C. Wilhelm 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 1 1863
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
82 6 13 _____ hr. _____ min.9. Birthplace Do not know 9
(City, town, or county) (State or foreign country)10. Usual occupation housewife

11. Industry or business _____

12. Name James Irwin13. Birthplace do not know 9
(City, town, or county) (State or foreign country)14. Maiden name do not know15. Birthplace do not know 9
(City, town, or county) (State or foreign country)16. (a) Informant M. Wilhelm(b) Address Seligman Mo.17. (a) burial (b) Date thereof 12/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Exeter Cem.18. (a) Signature of funeral director W. M. Jones(b) Address Cassville Mo.19. (a) Dec 31 1945 Grace Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Barry 5
(c) City or town Exeter 1
(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) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14
year 1945 hour 5 minute 30 P.M.21. I hereby certify that I attended the deceased from Dec 12 1945 to Dec 14 1945
that I last saw her alive on Dec 14 1945
and that death occurred on the date and hour stated above.Immediate cause of death Hemiplegia ✓
Duration _____

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Chas P. Brown (Name) or other _____Address Seligman Mo Date signed 12/13/45ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN _____

Underline
the cause to
which death
should be
charged sta-
tistically.

RECEIVED
District Health Officer No. 6,
District File Number 146-99
Date Filed JAN 22 1946

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 *C. M. Joiner*

Licensed Embalmer No. 3453

P. O. Address CASSVILLE, MISSOURI.

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.

2B
45
43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
100059

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 76

Registration District No. 11

Primary Registration District No. 4023

1. PLACE OF DEATH:
 (a) County Berry
 (b) City or town Carter
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days)

3. (a) PRINT FULL NAME Mary J. Wilhelm
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased: June 1
(Month) (Day) (Year)

8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____ (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 _____ year 1945 month _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Paraplegia
Cerebral Hemorrhage
Arteriosclerosis
 Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy Yes

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 C. R. Brown (M. D. or other) _____
 Address Belleville, Mo. Date signed Feb 3/46

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

1987