

FILED JUN 20 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 88

Primary Registration District No. 4457

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Steelville Mo
(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 Three years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford

(c) City or town Steelville Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? American (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Andrew Wilkinson

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

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

6. (b) Name of husband or wife Sabra Wilkinson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12-7-1880
(Month) (Day) (Year)

8. AGE:

Years <u>66</u>	Months	Days	If less than one day
			hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Maute Wilkinson

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

14. Maiden name Susan Ferguson

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

16. (a) Informant Virginia Wilkinson

(b) Address Steelville Mo

17. (a) _____ (b) Date thereof 3-26-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sholebrook Cemetery

18. (a) Signature of funeral director R. J. Jones

(b) Address Steelville Mo

19. (a) 6-10-46 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 26 th
year 1946 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Jan 1
1945 to med 26 1946
that I last saw him alive on med 25 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Astoria Salmonella

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 R. L. Parker (M. P. or other) _____

Address Steelville Mo Date 6-10-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

18746

RECEIVED

District Health Officer No. 5,

District File No.

646-378

Date Filed

6-19-46

AUG 11 1948

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 *Henry Jones*

Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

Henry Jones

Licensed Embalmer No.

2428

P. O. Address

Heehil & 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.