

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

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

State File No. 20850
Registrar's No. 77

FILED JUL 10 1946
Registration District No. 170

Primary Registration District No. 3033

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

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(c) Name of hospital or institution: Wallace Memorial
(d) Length of stay: In hospital or institution 6 days
In this community entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon
(d) Street No. 220 E. Commercial
(e) Citizen of foreign country? no.

3. (a) PRINT FULL NAME Israel Wilson
(b) If veteran, name war _____ (c) Social Security No. none

MEDICAL CERTIFICATION
23. DATE OF DEATH: Month May day 23 year 1946 hour 9 minute 25 P.M.
21. I hereby certify that I attended the deceased from 12/24/45 to 5/23/46
I last saw him alive on 5/23/46 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
(b) Name of husband or wife Flora M. Wilson (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 4 1867

Immediate cause of death Intestinal obstruction
Due to Adhesions
Paralytic ileus
Other conditions 2 2 2
Duration 6 days

8. AGE: Years 78 Months 11 Days 19 If less than one day _____ hr. _____ min.
9. Birthplace Kansas
10. Usual occupation Farmer

Major findings: Paralytic ileus - about 4 ft. of distended bowel
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER, FATHER { 12. Name Jack Wilson
13. Birthplace England
14. Maiden name Elizabeth Cox
15. Birthplace Georgia

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? _____
(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 John W. Beckham (M.D. or other) M.D.
Address 1184 W. Commercial Date signed 5/25/46

16. (a) Informant Mrs. Wade Allan
(b) Address Springfield Mo.
17. (a) Burial (b) Date thereof 5-25-46
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director W. T. Holman
(b) Address Lebanon Mo.
19. (a) May 27-46 (b) Orl Frankenberg
(Date received local registrar) (Registrar's signature)

152 (Licensed Embalmer's Statement on Reverse Side) Lebanon, Mo

Received7-5-46.....

Laclede County Health Unit

File No.5-46-79.....

Date Filed.....7-8-46.....

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 *Dorsey M. Howe*.....

Licensed Embalmer No. *4222*.....

P. O. Address *Lebanon 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.