

**FILED JUL 29 1946**  
Registration District No. **236**

Primary Registration District No. **4388**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County Osage  
(b) City or town Chambers, Mo.  
(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 and days 68

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Osage  
(c) City or town Chambers  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME:** Florence M Willson  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month July day 23  
year 1946 hour 1 minute 50 M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (c) Age of husband 76 years  
alive 27 1877  
(Day) (Year)

21. I hereby certify that I attended the deceased from 3-1 1946 to 7-20 1946  
that I last saw her alive on 7-20 1946  
and that death occurred on the date and hour stated above.

7. Birth date of deceased Nov (Month) 27 (Day) 1877 (Year)  
8. AGE: Years 68 Months 8 Days 25 If less than one day 13 hr. 50 min.

Immediate cause of death: Periphered circulatory failure  
Due to: Cerebral arteriosclerotic psychosis  
Due to: Essential hypertension followed by apoplexy  
Other conditions: apoplexy  
(Include pregnancy within 3 months of death)

9. Birthplace Mint Hill, Mo Rural (City, town, or county) (State or foreign country)  
10. Usual occupation Home Wife

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
Duration: 3 days  
1 yr.  
5 yrs.  
1 yr.  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

**MOTHER FATHER**  
11. Industry or business \_\_\_\_\_  
12. Name A B Matthews  
13. Birthplace Mint Hill Mo (City, town, or county) (State or foreign country)  
14. Maiden name Cordeeta Ague  
15. Birthplace Mint Hill Mo (City, town, or county) (State or foreign country)

16. (a) Informant Herbert Willson  
(b) Address Villa Ridge Mo

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? \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof 7 24 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St Aubert 7 24 46  
18. (a) Signature of funeral director Otto T. Storkach  
(b) Address Chambers Mo  
19. (a) \_\_\_\_\_ (b) E. Esther Sander  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature R O Jarvisworth (M. D. or other) Dr  
Address Chambers Mo Date signed 7-23-46

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 7-26-46

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, ~~and~~.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Otto T. Stoeckich

Licensed Embalmer No. 1902

P. O. Address Chamois, 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.

Registration District No. 256

Primary Registration District No. 2088

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Ozage  
(b) City or town Chambers  
(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

Florence M. Wilson

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Nov. 27 (Month) (Day) (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

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

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) Esther Souder  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Ozage  
(c) City or town Chambers  
(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 July 22  
year 1946 hour \_\_\_\_\_ 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 \_\_\_\_\_

Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

24910