

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36407

State File No. _____

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 154

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Excelsior Springs, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 mos. 20 days
(Specify whether years, months or days)
 In this community 7 mos. 20 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Oklahoma
 (c) City or town Oklahoma City
(If outside city or town limits, write "RURAL")
 (d) Street No. 919 N. E. 9th Street
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Nathaniel Wilson

3. (b) If veteran,

name war World War II

3. (c) Social Security

No. 445 07 8306

4. Sex Male 2 5. Color or race Colored
 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased November 27, 1905
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>40</u>	<u>11</u>	<u>18</u>	hr. _____ min. _____

9. Birthplace Wagoner Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation Assistant in morgue

11. Industry or business Hospital

12. Name James Wilson

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

14. Maiden name Alice (Last name unknown)

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

16. (a) Informant Hospital Records, Veterans Administration Hospital
 (b) Address Excelsior Springs, Missouri

17. (a) Removed (b) Date thereof Nov. 19 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: Removed to Oklahoma City, Okla.

18. (a) Signature of funeral director Urgid Hope
(Name of funeral home)
 (b) Address Excelsior Springs, Missouri

19. (a) 11/20/46 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 15
 year 1946 hour 8:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from March 27, 1946, to November 15, 1946, and that I last saw him alive on November 15, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary chronic, far advanced, active, severe.
Duration _____

Due to _____

Due to _____

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

Major findings: 13 B
 Of operations _____

Of autopsy No 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 it 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 of R. H. CAPLAN Clin. Dir. (M. D. or other) MD.
 Address Veterans Administration Hosp Date signed 11/5/46
Excelsior Springs, Mo.

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RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-2-46

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 James A. Moses

Licensed Embalmer No. 3296

P. O. Address Edelsior Springs

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.

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(a) County Clay
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(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
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 _____

3. (a) PRINT FULL NAME Nathaniel Wilson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex M
5. Color or race B
6. (a) Single, widowed, *married, divorced Married
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Nov. 27, 1901
(Month) (Day) (Year)

8. AGE: Years 40 Months 11 Days _____
If less than one day _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11/20/46 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Day _____
Year 1946 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY - USE UNFADING INK

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36407