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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 357

Registration District No. 209

Primary Registration District No. 2043

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

1. PLACE OF DEATH:  
(a) County MARION  
(b) City or town HANNIBAL (OAKWOOD)  
(c) Name of hospital or institution: 3301 Market  
Long Rest Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11 Months  
(Specify whether years, months or days) 4.5 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County MARION  
(c) City or town HANNIBAL 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1520 PARK 4  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ELKANA HENSON WILSON  
(b) If veteran, name war ✓  
(c) Social Security No. ✓

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 2 year 1946 hour 3 minute 09 A.M.  
21. I hereby certify that I attended the deceased from Oct-29-46 to Nov-2-1946  
that I last saw him live on Oct 29 1946  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife Katie Wilson  
6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased July 4 1874  
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis and Corneo-vascular Disease  
Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
72 3 23 hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 93D

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

10. Usual occupation Plumber

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

MOTHER FATHER  
12. Name Unknown 9  
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

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

16. (a) Informant Jesse Wilson (son)  
(b) Address 1520 Park - Hannibal Mo.

17. (a) BURIAL (b) Date thereof 11-4-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT Olivet - Hannibal

18. (a) Signature of funeral director C. E. Hopper  
(b) Address Clarence, 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? \_\_\_\_\_

19. (a) 11-4-46 (b) Dr E M Lucke  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 0  
23. Signature A. B. Blue (M. D. or \_\_\_\_\_)  
Address Hannibal Mo Date signed \_\_\_\_\_

189 (Licensed Embalmer's Statement on Reverse Side)

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**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..... *Louis E. Hopper* .....

Licensed Embalmer No..... *4261* .....

P. O. Address..... *Clarence, 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.**