

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16223**

Registration District No. **354**

Primary Registration District No. **6199**

Registrar's No. **131**

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Clinton
(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 74 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lexa¹⁰⁷
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. 3 mi. East of Cabool (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES ANDREW WILSON

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

4. Sex MO 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife BERTHA 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 5 1871 (Month) (Day) (Year)

8. AGE: Years 76 Months 1 Days 0 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John H Wilson

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

14. Maiden name RACHEL MATHIS

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

16. (a) Informant Bob Wilson

(b) Address Cabool Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Macedonia Cemetery Exoco

18. (a) Signature of funeral director Raymond V. Elliott

(b) Address Cabool Mo.

19. (a) April 6 (Date received local registrar) (b) Raynell Cunningham (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6 year 1947 hour 1 minute 45 M.

21. I hereby certify that I attended the deceased from November 1945 to April 5 1947 that I last saw him alive on April 5 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 10-15 years

Due to _____

Due to _____

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

Major findings: Of operations MB

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 Harriet (M.D. or other) _____

Address Cabool Mo. Date signed Apr 7/47

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

RECEIVED

District Health Officer No. 5,

District File Number 547260

Date Filed 5-10-47

OCT 3 1949

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.....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.