

FILED JUN 5 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17019

State File No.

Registration District No. 1060

Primary Registration District No. 5420

Registrar's No.

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Halscomb Rural
(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:

(a) State Missouri (b) County Dunklin
(c) City or town Halscomb, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 2 mi. E. Halscomb
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME HELEN IRENE WILSON

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

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased May 17 1932
(Month) (Day) (Year)

8. AGE: Years 14 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation School girl

11. Industry or business

12. Name Charley Wilson
13. Birthplace Dunklin Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name May Smithson
15. Birthplace Dunklin Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Charley Wilson

(b) Address Halscomb, Mo.

17. (a) Burial (b) Date thereof 5-4-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Starfield

18. (a) Signature of funeral director Walter Russell

(b) Address Piggott, Ark.

19. (a) (Date received local registrar) (b) J.A. Anderson (Registrar's signature) 5-9

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw h_____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Crushed Skull

Due to Stepping into path of oncoming auto, unavoidable
Due to Accident

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) Accident 3.5

(b) Date of occurrence

(c) Where did injury occur? Holcomb Dunklin Mo
(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)

23. Signature Walter Russell (Specify of physician or other)

Address Halscomb Mo Date signed 5-9-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Office

District File Number 647-52

Date Filed 6-2-47

JUN 6 1947

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.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. _____

Registration District No. 106 Primary Registration District No. 5420

1. PLACE OF DEATH:

(a) County Dunklin
(b) City or town Rural
(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

3. (a) PRINT FULL NAME

Helen J 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 s

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

7. Birth date of deceased May 17 1922
(Month) (Day) (Year)

8. AGE: Years 14 Months 11 Days 6 If less than one day _____ hr. _____ 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 _____ (State or foreign country)

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) J. J. Anderson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year _____ month _____ 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

17019