

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 30 1947

Registration District No. 238

Primary Registration District No. 5823

Registrar's No. 217

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

1. PLACE OF DEATH:

(a) County: New Madrid Co.

(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: L. F. E. (Specify whether)

years, months or days

3. (a) PRINT FULL NAME: CHARLET LOUIA WILSON

3. (b) If veteran, name war: No.

3. (c) Social Security No.: No.

4. Sex: Female!

5. Color or race: W

6. (a) Single, widowed, married, divorced: (1)

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: May 9
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>17</u>	hr. min.

9. Birthplace: New Madrid Co. Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation: Child

MOTHER FATHER

11. Industry or business _____

12. Name: Elmer Wilson (1)

13. Birthplace: New Madrid Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name: Elmer Wilson

15. Birthplace: East Prairie Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant: Ruby Mann's field

(b) Address: East Prairie, R. 1, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 25-47
(Month) (Day) (Year)

(c) Place: burial or cremation: Maudie

18. (a) Signature of funeral director: Friends

(b) Address _____

19. (a) 5-26-47 (Date received local registrar) (b) Helou Land Jones (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: New Madrid

(c) City or town: RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24 year 1947 hour 11:30 minute a.m.

21. I hereby certify that I attended the deceased from May 24, 1947 to May 24, 1947 that I last saw him alive on May 24, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocarditis

Due to: Primarily - at birth

Due to: _____

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

Major findings: 159

Of operations: _____

Of autopsy: _____

Duration

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: O. B. Chandler (M. D. or other) MD

Address: New Madrid Mo Date signed: 5/26/47

RECEIVED

District Health Office No. 2,

District File Number 647-897

Date Filed 6-26-27

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

Signed [Signature].....

Licensed Embalmer No. 3803.....

P. O. Address New York 720.....

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.