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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 14 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

429

State File No. ....

Registration District No. 47

Primary Registration District No. 3108

Registrar's No. 64

1. PLACE OF DEATH:  
(a) County Calloway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No 1 20  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 yrs 4 mo 15 day  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County 14  
(c) City or town St Louis 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4237 Market with  
(If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME WILLIAM WILSON  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 5  
year 1948 hour 10 minute 30 P.M.

4. Sex Male 5. Color or race negro  
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 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 3 1948 to Jan 5 1948  
that I last saw him live on Jan 3 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
27 1 18 hr. min.

Immediate cause of death  
Second degree burn on  
left side of body  
Due to accidently caught fire  
clothing  
Due to \_\_\_\_\_

9. Birthplace (City, town, or county) Ark (State or foreign country) 1

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Laborer

Major findings: Of operations 1st 15  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name Geo Wilson  
13. Birthplace (City, town, or county) Tenn (State or foreign country) 1

14. Maiden name St  
15. Birthplace (City, town, or county) Missyph (State or foreign country) 1

16. (a) Informant Records State Hosp No 1  
(b) Address Fulton mo 9 48  
17. (a) (b) Date thereof 1 9 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide accident 14  
(b) Date of occurrence Jan 3 - 1948  
(c) Where did injury occur: State Hosp No 1 Fulton Mo  
(City or town) (County) (State)

(c) Place: burial or cremations WASHINGTON PARK  
18. (a) Signature of funeral director A F Walton  
(b) Address 2707 Standard St

(d) Did injury occur in or about home, on farm, in industrial place, in public place? State Hosp  
While at \_\_\_\_\_ (Specify type of place)  
(e) Means of injury Burn  
Signature A R Price MD (M. D. or other) 0  
Address Fulton Mo Date signed 1-5-48

19. (a) (b) Jarie Morankhoff  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

X

**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 *Arthur L. Hilliard*

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayard a*

**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

429  
Feb  
State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 47 Primary Registration District No. 3008

1. PLACE OF DEATH:  
(a) County Callaway  
(b) City or town Fowler  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

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 \_\_\_\_\_

3. (a) PRINT FULL NAME William 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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Jan-17-1948  
(Month) (Day) (Year)

8. AGE: Years 27 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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) \_\_\_\_\_ (b) Joan Morrison (Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan Year 1948 hour \_\_\_\_\_ 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 \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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