

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25985**

FILED SEP 9 1949

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 254

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Kirksville) c. LENGTH OF STAY (in this place) 42 years		c. CITY (If outside corporate limits, write RURAL and give township) Kirksville 3	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Grim-Smith M. Hospital		d. STREET ADDRESS (If rural, give location) 810 E. Pierce St. 0	

3. NAME OF DECEASED (Type or Print) HERBERT	a. (First)	b. (Middle) CLARK	c. (Last) WILSON	4. DATE OF DEATH August 18, 1949
--	------------	--------------------------	-------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1-10-1877	9. AGE (In years last birthday) 72	if UNDER 1 YEAR 7 Months	if UNDER 12 Hrs. 8 Days	if UNDER 12 Hrs. 0 Min.
--------------------	-------------------------------	---	-----------------------------------	---	---------------------------------	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Funeral Director.	10b. KIND OF BUSINESS OR INDUSTRY Funeral Business	11. BIRTHPLACE (State or foreign country) Luray, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	--	--

13a. FATHER'S NAME George W. Wilson	13b. MOTHER'S MAIDEN NAME Mariah Jane Mathias	14. NAME OF HUSBAND OR WIFE Lenola Haywood Wilson
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME O.C. Wilson	ADDRESS 916 E. Jefferson St., Kirksville, Mo.
---	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4/221	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from Nov. 1947 to Aug 18, 1949, that I last saw the deceased alive on Aug 18, 1949, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE Spencer L. Freeman, M.D.	(Degree or title)	23b. ADDRESS Kirksville, Mo	23c. DATE SIGNED Aug 21, 1949
--	-------------------	------------------------------------	--------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-21-49	24c. NAME OF CEMETERY OR CREMATORY Maple Hills Cemet.	24d. LOCATION (City, town, or county) (State) Kirksville, Mo.
---	--------------------------	--	--

DATE REC'D BY LOCAL REG. 8-29-49	REGISTRAR'S SIGNATURE Wate Lambert	FUNERAL DIRECTOR'S SIGNATURE Davis Funeral Home, Kirksville, Mo	ADDRESS
---	---	--	---------

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

RECEIVED

SEP 6 1949

District Health Officer No. 1

District File Number 9-49-15

Date Filed SEP 6 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, _____

Student Embalmer No. _____

working under my personal supervision.

Signed Clarence M. Billo

Signed _____
Student Embalmer

Licensed Embalmer No. 4375

P. O. Address Kirkville, 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.