

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36182**

FILED DEC 1 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 343

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirkville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Worthington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>K. C. O. S. Hospital</u>		d. STREET ADDRESS (If rural, give location) _____	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Virgil</u> b. (Middle) <u>Ardel</u> c. (Last) <u>Wilson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>November 20, 1949</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 27, 1904</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Sylvia Wilson</u>	13b. MOTHER'S MAIDEN NAME <u>Dice Hurley</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Wilson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Pearl Wilson</u>	ADDRESS <u>Worthington Mo</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERNAL BETWEEN ONSET AND DEATH <u>2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Paralytic ileus</u>		
	ANTECEDENT CAUSES As forid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Toxemia due to liver failure</u> DUE TO (c) <u>Kidney failure - circulatory failure</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>partial obstruction of ascending colon</u>			

19a. DATE OF OPERATION <u>11-14-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>acute Phlegmonous Appendicitis with adhesive Bands causing</u>	19c. AUTOPSY? <u>partial obstruction of ascending colon</u> YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from June 15 1944, to November 20 1949, that I last saw the deceased alive on November 20, 1949, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Howard E. Goss, D.D.</u>	23b. ADDRESS <u>Kirkville, Mo.</u>	23c. DATE SIGNED <u>11-21-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11/20/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Brassfield Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Worthington, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>11-21-49</u>	REGISTRAR'S SIGNATURE <u>Rate Lambert</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm N West</u>	ADDRESS <u>Quincy Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 22 1957

NOV 28 1949

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 11-49-1

Date Filed NOV 28 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Wm H West

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2882

P. O. Address Greencity 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.