

FILED SEP 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29583

BIRTH NO. 46730-50 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 3007 Registrar's No. 252

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Castor <u>1030</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hospital		d. STREET ADDRESS (If rural, give location) Bloomfield, Mo. Rural # 3	

3. NAME OF DECEASED (Type or Print) a. (First) JERRY	b. (Middle) DEAN	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Mar. 26, 1950	9. AGE (In years last birthday) -	IF UNDER 1 YEAR Months 5	IF UNDER 1 YEAR Days 6	IF UNDER 1 HR. Hours -	IF UNDER 1 HR. Min. -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bloomfield, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Howard Wilson	13b. MOTHER'S MAIDEN NAME Eva Martin	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Howard Wilson, Bloomfield, Mo.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gastroenteritis acute		3 days
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		490 X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 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) (Min.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank E. Dinech, Jr. D.D.	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 4, 50	24c. NAME OF CEMETERY OR CREMATORY Walkers cem.	24d. LOCATION (City, town, or county) (State) Stoddard Co. Missouri
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DATE REC'D BY LOCAL REG. Sept 11-1950	REGISTRAR'S SIGNATURE Wm. H. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHILES UND. CO. Bloomfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED

SEP 19 1950

BUTLER CO. HEALTH CENTER

FILE No. 950-378

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 Lulu

Cooper # 3499

working under my personal supervision.

Student Embalmer No.

Signed

Jim C. Cooper

Signed.....

Student Embalmer

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.