

FILED APR 16 1951

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **13236**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 201 PRIMARY REG. DIST. NO. 4312 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Macon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>La Plata</u>		c. LENGTH OF STAY (in this place) <u>11 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>La Plata</u>		<u>0610</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>XXX</u>			d. STREET ADDRESS (If rural, give location) <u>X</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hattie</u> b. (Middle) <u>Amanda</u> c. (Last) <u>Wilson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 24 1951</u>		
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 18, 1871</u>		9. AGE (in years last birthday) <u>80</u>
			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13a. FATHER'S NAME <u>Richard Livingston</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Selby</u>		14. NAME OF HUSBAND OR WIFE <u>James I. Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Leona Workman La Plata, Mo</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u> <u>unk.</u> <u>unk.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION  <u>4200</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	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 <u>May 6, 1949</u> , to <u>March 24, 1951</u> , that I last saw the deceased alive on <u>March 24, 1951</u> , and that death occurred at <u>11:30 P. M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>M. Robert Knapp, M.D.</u>		23b. ADDRESS <u>La Plata, Mo.</u>		23c. DATE SIGNED <u>3/30/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Mar. 28-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Gibbs Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Gibbs, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>4-13-51</u>	REGISTRAR'S SIGNATURE <u>Edith B. Sears</u>	186	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopper Funeral Service</u>		

Dr. Robert Knapp - La Plata, Mo.

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

REC'D 4.13.51  
MASON COUNTY HEALTH DEPARTMENT  
County File No. 4.51.66  
Date Filed 4.13.51  
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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.

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

Signed \_\_\_\_\_

Licensed Embalmer No. 4726

P. O. Address Clarence

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.