

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **5713**  
Registrar's No. **138**

FILED MAR 15 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **198** PRIMARY REG. DIST. NO. **5740**

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>MACON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Lingo township</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural-Lingo township</b>	
c. LENGTH OF STAY (in this place) <b>2 days</b>		d. STREET ADDRESS (If rural, give location) <b>5 miles S. of New Cambria</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4 1/2 miles S. of New Cambria</b>		5. MILEAGE (In years last birthday) <b>80</b>	

3. NAME OF DECEASED (Type or Print) **Fountain C. Wilson**

a. (First) **Fountain** b. (Middle) **C.** c. (Last) **Wilson**

4. DATE OF DEATH (Month) (Day) (Year) **Feb. 22, 1952**

5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Oct. 20, 1862</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Days <b>3</b>	IF UNDER 24 HRS. Hours <b>23</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Randolph County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Fountain Wilson</b>	13b. MOTHER'S MAIDEN NAME <b>Polly Ann Shoemaker</b>	14. NAME OF HUSBAND OR WIFE <b>No</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>R.E. Shoemaker</b>	ADDRESS <b>New Cambria, Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Influenza</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Age infirmities</b> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	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 **Feb 20, 1952** to **Feb 22, 1952**, that I last saw the deceased alive on **Feb 21, 1952**, and that death occurred at **4:15 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>R. D. West M.D.</b>	23b. ADDRESS <b>New Cambria Mo. Feb 22-52</b>	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Feb. 24, 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Rice Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Chariton County, Mo.</b>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>2-29-52 Josephine Kery</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>H. G. Lilliland New Cambria Mo.</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300  
0.48

10

0

RECEIVED 3.12.52  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 35246  
Date Filed 3.13.52

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 *J. P. Gilleland*

Licensed Embalmer No. 4019

P. O. Address *New Pambria, 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.