

STANDARD CERTIFICATE OF DEATH

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

BIRTH NO. _____ REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 6934 Registrar's No. 52

1. PLACE OF DEATH a. COUNTY Warren		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Warren	
b. CITY (If outside corporate limits, write RURAL and give town) Truesdale		c. LENGTH OF STAY (in this place) 2 yrs.	c. CITY OR TOWN Truesdale
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		f. STREET ADDRESS (If rural, give location) 109⁰ 0	

3. NAME OF DECEASED (Type or Print) a. (First) Deanie b. (Middle) Ray c. (Last) Wilson			4. DATE OF DEATH (Month) (Day) (Year) July 4, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Mar. 31, 1952	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 3 Days 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Washington, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Houston Wilson		13b. MOTHER'S MAIDEN NAME Virginia Laverne Young		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Houston Wilson ADDRESS Truesdale, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma - Brain (Cerebellum)		DUE TO (b) _____		3 1/4 mo.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 Dec. 1954		19b. MAJOR FINDINGS OF OPERATION Tumor mass in Cerebellum		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) (Min.)		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 1-3-, 1954 to 7-4-, 1954, that I last saw the deceased alive on 7-4-, 1954, and that death occurred at 9:20 p. m., from the causes and on the date stated above.

23a. SIGNATURE H. Walter Corman M.D. (Degree or title)		23b. ADDRESS Thompson		23c. DATE SIGNED 7.5.54	
24a. BURIAL CREMATION REMOVAL Removal		24b. DATE 7-5-54		24c. NAME OF CEMETERY OR CREMATORY Local Cemetery	
		24d. LOCATION (City, town, or county) (State) McCrory Arkansas			

DATE REC'D BY LOCAL REG. 7-6-54		REGISTRAR'S SIGNATURE Floyd Logan		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thompson-Wilson F.H., McCrory, Ark.	
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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.....
Signature of Student Embalmer

Signed.....
John Hieburg

Licensed Embalmer No... *389*

P. O. Address *Warrenton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.