

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 21 1955

5674 State File No. 5527

BIRTH MO. _____		REG. DIST. NO. 187		PRIMARY REG. DIST. NO. 3040		Registrar's No. 57			
1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u>				b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, HW36, Chillicothe - Assisted</u>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>Chillicothe</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1/2 Mile S. Chillicothe</u>				e. STREET ADDRESS (If rural, give location) <u>804 State St.</u>				0592	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Merl</u>			b. (Middle) <u>Dean</u>		c. (Last) <u>Wilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 12 55</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W/US</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>2-23-28</u>		9. AGE (In years last birthday) <u>26</u>	10. F UNDER 1 YEAR Months	10. F UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Wheeling, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Russell Wilson</u>			13b. MOTHER'S MAIDEN NAME <u>Flora K. Albertson</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>491-30-2015</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Russell E. Wilson, Chillicothe, 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shock, Severe,</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Fractured, Neck</u> DUE TO (c) <u>Fractured Ribs</u> II. OTHER SIGNIFICANT CONDITIONS <u>Contusion of Brain</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Five Minutes</u> <u>Five Minutes</u> <u>Five Minutes</u> <u>Five Minutes</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. SUICIDE (Specify) HOMICIDE <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, shop, factory, street, office bldg., etc.) <u>Hi Way 36</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Chillicothe, Livingston, Mo</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb-12-55 7:18 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>None</u> 19____, to _____, 19____, that I last saw the deceased <u>Feb 15</u> , 1955, and that death occurred at <u>7:29 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Joseph A. Conrad M.D. (Coroner)</u> (Degree or title)				23b. ADDRESS <u>Chillicothe, Mo</u>		23c. DATE SIGNED <u>Feb. 15-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-14-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wheeling</u>		24d. LOCATION (City, town, or county). (State) <u>Wheeling, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>2-15-55</u>		REGISTRAR'S SIGNATURE <u>Francesca B. Neal</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Frenzel</u>		ADDRESS <u>Home, Chillicothe, Mo</u>			

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

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 *Joseph M. Gibson*.....

Licensed Embalmer No. *476*

P. O. Address *Chillicothe*

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.