

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047520

STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. 5333 Registrar's No. 63-77

FILED JAN 2 1964

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grant Twp</u>		Length of stay in lb <u>38 yrs.</u>	c. CITY OR TOWN <u>Golden City R.F.D. 2</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Golden City R. 2</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 3/4 Mi. SE Golden City</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJIMAN EARL WILSON</u>			4. DATE OF DEATH Month Day Year <u>Dec. 22, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/93</u>
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and state or country) <u>Sarcoxie, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry Clay Wilson</u>	
13b. MOTHER'S MAIDEN NAME <u>Miriam Elizabeth McClure</u>		14. NAME OF HUSBAND OR WIFE <u>Eva Ellen Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>Mrs. Eva Ellen Wilson, Golden City R2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>April 1963</u> to <u>Dec 22, 1963</u> and last saw him alive on <u>Dec 4, 1963</u> Death occurred at <u>5:20 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold A. Bauer, M.D.</u>		22b. ADDRESS <u>Lockwood, Mo</u>	22c. DATE SIGNED <u>12-24-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>12/26/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sarcoxie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sarcoxie, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Phillips-Pugh Funeral Home Golden City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12/26/1963</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>

USE BLACK INK

OR
TYPEWRITER RIBBON
Harold A. Bauer, M.D.

05712 07-20-28

DEPARTMENT OF HEALTH

Issue Date

Date

Golden City, Mo.

May 28

Golden City, Mo.

Golden City, Mo.

Golden City, Mo.

Dec. 25, 1928

MOBILE

ISSUE

EXPIRES

12/25/28

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Golden City, Mo.

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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 W. A. Bugh

Licensed Embalmer No. 3278

P.O. Address Golden City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

12/25/28
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