

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **355521**

Registration District No. **587**

Primary Registration District No. **4335**

Registrar's No. **53**

1. PLACE OF DEATH:

(a) County **Moniteau**
(b) City or town **California**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **Four Months**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Dr. Harold Stephen Wilson, M.D.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Dorothy E. Wilson** 6. (c) Age of husband or wife if alive **29** years
7. Birth date of deceased **July 9 1908**
(Month) (Day) (Year)

8. AGE: Years **33** Months **3** Days **7** If less than one day hr. min.

9. Birthplace **Fortuna Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Medical Doctor**

11. Industry or business

12. Name **Dr. G.S. Wilson**
13. Birthplace **Miller O County**
(City, town, or county) (State or foreign country)
14. Maiden name **Cleo M. McClure**
15. Birthplace **Miller O County**
(City, town, or county) (State or foreign country)

16. (a) Informant **Wanda A. Lammert**
(b) Address **Versailles, Mo. R.F.D.**

17. (a) **Removal** (b) Date thereof **10-16-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **California Masonic Cem.**

18. (a) Signature of funeral director **James E. Richards**
(b) Address **Versailles, Mo.**

19. (a) **10-16-41** (b) **Dr. H. H. H. H.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Moniteau**
(c) City or town **California**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **16**
year **1941** hour **5** minute **30** A.M.

21. I hereby certify that I attended the deceased from **Oct 15** to **Oct 16** 19**41**
that I last saw him alive on **Oct 15** 19**41**
and that death occurred on the date and hour stated above.
Immediate cause of death **Pneumonia** Duration **2 days**
Labar. both lungs.

Due to **Cause unknown.**

Due to **Also had pulmonary tuberculosis.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (e) Means of injury

23. Signature **L. L. Latham** (M. D. **th**)
Address **California Mo** Date signed **10-16-41**

WRITE PLAINLY—USE 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 he} ~~was~~ embalmed by me, or by.....

.....; Registered Apprentice No.

working under my personal supervision.

Signed

James E. Richards

Licensed Embalmer No. *2466*

P. O. Address *Tipton, 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.