

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38355

State File No. ....

FILED NOV 30 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1210

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (In this place) <u>7 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <u>0117</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2502 Duncan Street</u>		d. STREET ADDRESS (If rural, give location) <u>2502 Duncan Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Hildred</u> b. (Middle) <u>Dean</u> c. (Last) <u>Wilson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 14, 1953</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 17, 1881</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeping</u>	11. BIRTHPLACE (State or foreign country) <u>Windsor, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Walter T. Elliott</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Lamb</u>	14. NAME OF HUSBAND OR WIFE <u>George E. Wilson</u>
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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>188-26-3029</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Walter E. Wilson</u>	ADDRESS <u>St. Joseph, Mo</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Left lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) _____		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis generalized</u>			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>163X</u>	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 8-13, 1953, to 11-14, 1953, that I last saw the deceased alive on 11-12, 1953, and that death occurred at 12:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Irwine B. Benthall M.D.</u>	23b. ADDRESS <u>St. Joseph Mo</u>	23c. DATE SIGNED <u>11-16-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>11/16/1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Nov. 24, 1953</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Newton Bowman</u>	ADDRESS <u>St. Joseph Mo</u>
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WRITE PLAINLY—USING 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 .....  
Student Embalmer

Signed

*William Spelling*

Licensed Embalmer No. 4535

P. O. Address 319 51st St. W. Wash D.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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