APR 22 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH
County: Andrain
Township: Cuyuse
City: Vandalia
Registration District No. 912
Primary Registration District No. 6232A
File No. 7153
Registered No. 23
(No. ..... St. ..... Ward)

2. FULL NAME: Mary E. Wilson
(a) Residence: No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: CU
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. ~~IF MARRIED~~, WIDOWED, ~~OR DIVORCED~~ HUSBAND OF (OR) WIFE OF: Harvey Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 10-16-1837

7. AGE: Years 89, Months 5, Days 15, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Simon Bronstetter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Jane Bronstter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

14. INFORMANT: E. J. Wilson
(Address): Vandalia Mo

15. FILED: 4/1, 1927 Mollie Fuqua, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3-31 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 12, 1927, to Mar 31, 1927, that I last saw her alive on Mar 31, 1927, and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Erysipelas of face and head
Mex
108
15B
(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (SECONDARY): Lobar Pneumonia
(duration) ..... yrs. ..... mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. O. Terrill, M. D.
, 19 (Address) Vandalia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: New Harmony Mo
DATE OF BURIAL: 4-2 1927

20. UNDERTAKER: W S Wales
ADDRESS: Vandalia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.