

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

Do not use this space.

6109

1. PLACE OF DEATH

County Jefferson
Township St. Louis
City St. Louis (No. _____)

Registration District No. 314
Primary Registration District No. 4190

File No. _____
Registered No. 15
St. _____ Ward _____

2. FULL NAME Miss Mary Jane Wilson

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED (or) WIFE OF Geo Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 15 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 7 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Jefferson
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER John Calender

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Ind.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY) _____

14. INFORMANT George E. Wilson
(Address) St. Louis

15. FILED 2/22/29 Carl S. Beard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to Feb 21, 1929 that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at 11:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Interstitial Nephritis
12!
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 129a
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. B. Simpson, M. D.
, 19 (Address) St. Louis, Mo.

*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 St. Louis MO DATE OF BURIAL 2/23 29

20. UNDERTAKER Kate H. Phillips ADDRESS St. Louis

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.

MAR 22 1929

235

400
200

400
1600