

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

Do not use this space.

18224

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis, Mo. (No. City Hospital # 2)

File No.....  
Registered No. 5419.  
St. .... Ward)

**2. FULL NAME**

Della Wilkeson  
(a) Residence. No. 3110 Franklin St. 21 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 <u>Female</u>	4. COLOR OR RACE <u>col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>abt 50</u>	YEARS <u>-</u>	MONTHS <u>-</u>
	DAYS <u>-</u>	If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House - work</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Ark  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT G. Gertrude Creath  
(Address) City Hospital # 2

15. FILED JUN - 3, 1930 Max Estaker  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-31-1930  
17. I HEREBY CERTIFY, That I attended deceased from 5-28-1930 to 5-31-1930 that I last saw h. et. alive on 5-31-1930 and that death occurred, on the date stated above, at 1:55 P.M.  
THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
121  
92A (duration) - yrs. - mos. 3 ds.  
CONTRIBUTORY Chronic Nephritis  
(SECONDARY) (duration) - yrs. - mos. - ds. 6 mos. - ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH? No DATE OF .....  
WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) A. E. Hale M. D.  
6/2/1930 (Address) City Hospital # 2

\*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 Greenwood DATE OF BURIAL June 4 1930

20. UNDERTAKER Starrison ADDRESS Lawton

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

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2  
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