

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

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.

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

4269

1. PLACE OF DEATH

County St. Louis
Township Carroll Creek
City St. Louis (No. _____)

Registration District No. 845
Primary Registration District No. 6108A

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

2. FULL NAME

Lera Maxine 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 20 / 1930

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
		<u>1</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Leslie Wilson

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

12. MAIDEN NAME OF MOTHER Elizabeth Mitchell

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

14. INFORMANT Leslie Wilson
(Address) Galena Mo

15. FILED 12/31/30 D. S. Schumate
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1930 to Dec 31 1930 that I last saw her alive on Dec 31 1930 and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Croup pneumonia (bronchitis)
10/19/30 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____
(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) D. S. Schumate M. D.
1/10/31 (Address) Reeds Spring 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 Worshipful Cemetery DATE OF BURIAL 1/8/31

20. UNDERTAKER Mrs. Hattie Stults ADDRESS Reeds Spring Mo

