

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

Do not use this space.

30386

SEP 21 1936

1. PLACE OF DEATH

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

Registration District No. 229
Primary Registration District No. 4139

File No. _____
Registered No. _____

2. FULL NAME

Melissa Belle 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-27-1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>55</u>	<u>11</u>	<u>25</u>		

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington Co Mo.

FATHER 13. NAME William D. Griggs

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

MOTHER 15. MAIDEN NAME Gerilda Adams

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

17. INFORMANT Madison Wilson (ADDRESS) St. Louis

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary DATE 8/23/36

19. UNDERTAKER (ADDRESS) Chapman St. Louis

20. FILED 8-24 1936 Quadrant Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-22-1936

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 8:45 A.M.

The principal cause of death and related causes of importance were as follows:

Myocarditis
Tuberculosis
Other contributory causes of importance: _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) Albert Chouy Brown M.D. (Address) St. Louis Mo.

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1. PLACE OF DEATH

County Crawford
Township
City Bourbon (No., St. Ward)

Registration District No. 229
Primary Registration District No. 4139

File No.
Registered No.

2. FULL NAME Melissa Belle Wilson

(a) Residence, No. St. Ward. (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<u>23</u>	<u>11</u>	<u>25</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19..

19. UNDERTAKER (ADDRESS)

20. FILED 8-24 St. Cupdons Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-22, 1936

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Myocarditis Date of onset

Other contributory causes of importance:

Tuberculosis
Pulmonary embolism
Septicemia
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....

(Signed) Albert E. Long Registrar
(Address) Bourbon Mo

SUPPLEMENTARY

S-30386