

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.

Registration District No. 701
1008 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Belle Burroughs Wilson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Joshua Wilson 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 3 8 1864
(Month) (Day) (Year)

8. AGE: Years <u>75</u>	Months <u>2</u>	Days <u>23</u>	If less than one day hr. _____ min. _____
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9. Birthplace Monroe Co. Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
12. Name W. S. Burroughs
13. Birthplace Monroe Co. Ill
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Johnston
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Josephine Burroughs
(b) Address Columbia 222

17. (a) Removal (b) Date thereof 7-3-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Waterloo Ill.

18. (a) Signature of funeral director Schwartz Funeral Home
(b) Address Columbia 222

19. (a) JUL 1 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Monroe
(c) City or town Columbia, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st
year 1939 hour 2:05 minute A M.

21. I hereby certify that I attended the deceased from Apr. 21, 1939, to July 1, 1939;
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 6 mos
acute dilatation of heart
Due to myocarditis
Due to Chronic Cholelithiasis 3 yrs.
unknown as to stones
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: None gpc
Of operations _____
Of autopsy None
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or public place? _____

While at work? _____ (Specify type of place) _____
(a) Means of injury _____
23. Signature Charles Whitt (M. D. or other) _____
Address 508 N. Grand Date signed 7-3-39
St Louis Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Howard G. Rowland

Licensed Embalmer No. 3114

P. O. Address Thomas, N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.