

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26767**
Registrar's No. **6663**

Registration District No. **791**

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
6053 Pershing Ave. **9**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME **ERA WILKERSON RENOE** **500**

8. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

4. Sex **female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Charles B. Renoe** 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **May** **27** **1870**
(Month) (Day) (Year)

8. AGE: Years **70** Months **2** Days **7** If less than one day _____ hr. _____ min.

9. Birthplace **Linneus** **Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business **at home**

MOTHER FATHER { 12. Name **Joel Wilkerson**
13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **Judith Morain**
15. Birthplace **Pepper County** **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **June Renoe**

(b) Address **#16053 Pershing Ave**

17. (a) **Cremation** (b) Date thereof **8-15-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Crem**

18. (a) Signature of funeral director **C. B. Depton & Son**

(b) Address **#733 Delmar Blvd.**

19. (a) **AUG 6 1940** (b) **J. F. [Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. **6053 Pershing Avenue**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **3rd**
year **1940** hour **2** minute **30** M.

21. I hereby certify that I attended the deceased from **Aug 1**
Aug 1 19**40** to **Aug 3** 19**40**
that I last saw her alive on **Aug 2** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocarditis** **140**

Due to **Paralysis Aiptous** **5-40**

Due to _____

Other conditions: **1940**
(Includes pregnancy within 3 months of death)

Major findings: **1940**
Of operations _____
Of autopsy _____

Duration
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, in public place?

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **MD**
Address **402 West 1st St** Date signed **8-3-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Victor Kieffer
4500 Olive St.
Fo - 3800
12:30 - 5 PM

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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.....

Don Macchary....., Registered Apprentice No. 214
working under my personal supervision.

Signed *Clarence A. Murray*
Licensed Embalmer No. 4011
P. O. Address St. Louis, Mo.

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.