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NOV 23 1940 34939
State File No. 34939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 258

4
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2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
 (a) County O'Fallon
 (b) City or town Fulton
 (c) Name of hospital or institution: State Hosp. #1
 (If not in hospital or institution, give street number or location)
 (d) Length of stay: In hospital or institution 11 days
 (Specify whether
 In this community
 years, months or days)

3. (a) PRINT FULL NAME Lethia Rana Wilson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Graham Wilson 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased Nov. 20 1865
 (Month) (Day) (Year)

8. AGE: Years 74 Months 74 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Mississippi (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER
 12. Name James McPemore
 13. Birthplace Mississippi (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Revis
 15. Birthplace North Carolina (City, town, or county) (State or foreign country)

16. (a) Informant Graham Wilson
 (b) Address 8747 Agnes Ave. Brentwood Mo.

17. (a) Removal (b) Date thereof 10 8-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Louis Co. Mo.

18. (a) Signature of funeral director J. Reeves
 (b) Address 24 Kearsley Av. Webster Groves

19. (a) 10/5/40 (b) R. N. Crews
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis County
 (c) City or town Brentwood
 (If outside city or town limits, write "RURAL")
 (d) Street No. 8747 Agnes St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 4 year 1940 hour 5 minute 15 A M.

21. I hereby certify that I attended the deceased from 10-3 1940 to 10-4 1940
 that I last saw her alive on 10-3 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Ch. Myocarditis
with Arteriosclerosis

Due to _____
 Due to 1/2 C
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Hypertrophy of Heart
Chronic Passive Congestion
 Of autopsy Tuberculosis

Duration
 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) No
 (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? No

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

23. Signature J. Wood (M. D. or other) _____
 Address State St. #1, Fulton Date signed 10/4/40

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

J. A. Lewis

Licensed Embalmer No. *2027*

P. O. Address *27 Euclid Webster Groves*

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, fact should be so stated above.

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 104

Primary Registration District No. 3008

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Lethia Rana Wilson

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

4. Sex F 5. Color or race col 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 10 14 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Apr 10, 1941 (b) P. N. Crews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

20. DATE OF DEATH: Month Oct day 4
year _____ hour _____ minute _____ M.

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

Immediate cause of death _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

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 G. J. Wood (M. D. or other) _____
Address Fulton Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

