

FILED APR 6 1942

Registration District No. 184

Primary Registration District No. 200

Registrar's No. 694

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 yr 0 mo 23 days  
(Specify whether  
in this community 18 years  
years, months or days)

3. (a) PRINT FULL NAME WILMA C THRELKELD

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. NO

4. Sex Female 5. Color or race negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Thomas Threlkeld 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. April 14 1917  
(Month) (Day) (Year)

8. AGE: Years 24 Months 10 Days 9 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Will Coleman

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

14. Maiden name Viola Redman

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

16. (a) Informant Hospital record

(b) Address Robert Koch Hosp

17. (a) Burial (b) Date thereof 3. 28. 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farther Dickson

18. (a) Signature of funeral director Atkins Bros and Co

(b) Address 3644 Finney Ave

19. (a) MAR 28 1942 (b) St. M. L. L. L. L.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3149 Kasloide Ave  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23  
year 1942 hour 1 minute 05 A.M.

21. I hereby certify that I attended the deceased from Feb 28 1941 to March 23 1942  
and that death occurred on the date and hour stated above.  
that I last saw him alive on March 23 1942

Immediate cause of death Pulmonary Hemorrhage

Due to Pulm. Tuberculosis 4 yr +

Due to \_\_\_\_\_

Other conditions P  
(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 D

23. Signature Frank Cohen (M. D. or other) MD  
Address Robert Koch Hosp Date signed 3/23/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

76  
0  
0

707

APR 9 1942

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

*Louis V. Atkins*

Licensed Embalmer No. *2842*

P.O. Address *3644 Finney av*

**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.**