

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30542**
Registrar's No. **8702**

FILED OCT 13 1943

Registration District No. **1002** Primary Registration District No. **1002**

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME **Anna H. Wilkinson**

3. (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 **Edw. Leo Wilkinson** 6. (c) Age of husband or wife if alive **60** years
7. Birth date of deceased **December 14, 1885**
(Month) (Day) (Year)

8. AGE: Years **57** Months **9** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

MOTHER FATHER { 12. Name **John Hopp**

13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Minnie Hoffman**

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

16. (a) Informant **Edw. L. Wilkinson**

(b) Address **8708 Alva**

17. (a) **Burial** (b) Date thereof **10-2-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla**

18. (a) Signature of funeral director **Stroot-Carroll**

(b) Address **4600 Natural Bridge Ave/**

19. (a) **OCT 1 1943** (b) **J. F. Brueck**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Steelville**
(If outside city or town limits, write "RURAL")
(d) Street No. **8708** (If rural, give location)
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **29**
year **1943** hour **8** minute **30 P.** M.

21. I hereby certify that I attended the deceased from **June** 19 **43** to **Sept** 19 **43**
that I last saw her alive on **Sept 29** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

uremia -
Due to **Renal insufficiency**

Due to **Renal stone R. kidney -
Pyelonephritis L. kidney**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **13**
Of autopsy **Miliary TB of lung from
T.B. both kidneys**

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, in public place?

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **Kenneth Wilson** (M. D. or other) **10-1-43**
Address **634 N. Grand** Date signed **10-1-43**

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

100
977
9

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 *Sheldon Collier*.....

Licensed Embalmer No. *3382*.....

P. O. Address.....

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.)

NOTE: If this body is not embalmed, fact should be so stated above.