

No. 2-43
17-39
X35697

State File No. _____
Registrar's No. 810

FILED APR 30 1944

Registration District No. _____

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Koch, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rob't. Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 mo., 22 days
(Specify whether years, months or days)
In this community 5 mo., 22 days

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. 4358/a Cook Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Virginia Rowan Wilson

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

4. Sex F
5. Color or race N
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Clarence H. Wilson
6. (c) Age of husband or wife if alive 39 years
7. Birth date of deceased 8 10 09
(Month) (Day) (Year)

8. AGE: Years 34 Months 7 Days 21
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Teacher

MOTHER FATHER

12. Name Wm. H. Rowan
13. Birthplace Cape Girardeau Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Morris
15. Birthplace Cape Girardeau Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Patient
(b) Address _____

17. (a) Burial (b) Date thereof 4/4/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Saint Peter's Cem.

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Avenue

19. (a) APR 5-1944 (b) E. G. McCarren, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31
year 44 hour 11 minute 00 P.M.
21. I hereby certify that I attended the deceased from 10/8
19 43 to 3/31 19 44
that I last saw her alive on 3/31/44
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 15mo

Due to _____
Due to _____
Other conditions 1st. stage Thoracoplasty 10 days
(Include pregnancy within 3 months of death)

Major findings: Pulmonary Tuberculosis
Of operations _____
Of autopsy Pulmonary Tuberculosis
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) 1361
(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)
Means of injury _____
23. Signature Samuel S. Rowan (M. D. owner)
Koch Hosp. Koch, Mo Date signed 4/1/44
Address _____

AUG 19 1948

SEP 9 1948

APR 7 1944

STATEMENT BY LICENSED EMBALMER

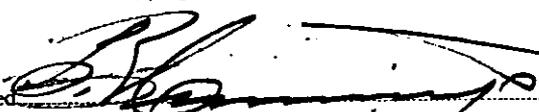
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Robert Lee Cummings

Registered Apprentice No.....

working under my personal supervision.

Signed



Licensed Embalmer No. 4363

P. O. Address 4107 Finney Avenue

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.