7. S. No. 2
0M—5-42
ev. 5-17-38
1 x

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27025
3313

FILED AUG 23 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town K. C. Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST LUKES HOSPITAL O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 DAYS (Specify whether years, months or days)

In this community SAME

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County GENTRY

(c) City or town STANBERRY
(If outside city or town limits, write "RURAL")

(d) Street No. NO
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MARY FLO WAKEFIELD

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex FEMALE

5. Color or race WHT.

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Charles E.

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased June 28 1918
(Month) (Day) (Year)

8. AGE: Years 26 Months 1 Days 12 If less than one day hr. min.

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

10. Usual occupation at home

11. Industry or business

MOTHER FATHER

12. Name Frank H. Dillea

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

14. Maiden name Maud Hawkins

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

16. (a) Informant Mrs. Maud Wilson

(b) Address Stanberry Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-10-44 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ STANBERRY MO

18. (a) Signature of funeral director STINE McCLURE

(b) Address K. C. Mo

19. (a) 8-11-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10 year 1944 hour 12 minute 52 A. M.

21. I hereby certify that I attended the deceased from August 1, 1944, to August 10, 1944, that I last saw her alive on August 9, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia with Anuria	8 days
Due to: Post partal Eclampsia with Obstipation Placenta	8 days
Due to: Twin pregnancy	8 mos
Other conditions (Include pregnancy within 3 months of death): Acquired Hemolytic 1948 Anemia Kleins-Aplieno Jaundice 1939	
Major findings of operations: Twin pregnancy with extensive separation.	
Of autopsy: Acute swelling of kidney & liver, anuria, Ct. Iliac thrombosis	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Nelson Singleton M.D.
Address 311 Alameda Road Date signed 8-10-44

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 1465

P. O. Address K. C. 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, fact should be so stated above.