

S. No. 2
M-8-43
7-5-17-39
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14639

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAY 14 1945

Registration District No. 317

Primary Registration District No. 3070

Registrar's No. 837

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
118 South Gore Avenue
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 118 South Gore Avenue
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Olive Adeline Wilcox

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

3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife Robert W. Wilcox

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased 8/14/1882
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>7</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation At home

11. Industry or business Housewife

12. Name George Cole

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

14. Maiden name Elizabeth Brawley

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

16. (a) Informant Robert W. Wilcox

(b) Address 118 South Gore Avenue

17. (a) Burial (b) Date thereof 4/5/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hannibal, Mo.

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) APR 5 1945 (b) E. G. McFarland
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1945 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from 2/3/45
1945 to 4/3/45, 1945

that I last saw her alive on 4/3/45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of sigmoid, with metastases to liver, omentum & stomach.

Due to Op. operated on by Dr. John B. Hayward 2/8/45

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Ring carcinoma of sigmoid, carcinoma of liver

Of autopsy No autopsy if 62

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) _____

(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)

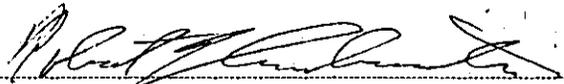
Signature Ellsworth B. Whitman (M.D. or D.V.M.)

Address #5 North Gore Ave. Date signed 4/3/45

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

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. 1994.....

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.)

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