S. No. 2
M—5-43
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I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15711

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4202

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5617 Vernon Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5617 Vernon Avenue
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Jane Wilkinson
3. (b) If veteran, name war No.
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. 12, 1870 (Month) (Day) (Year)
8. AGE: Years 74 Months 7 Days 28 If less than one day hr. min.
9. Birthplace Lawrenceville, Ind. (City, town, or county) (State or foreign country)
10. Usual occupation At home
11. Industry or business Not employed
FATHER 12. Name George Wilkinson
FATHER 13. Birthplace Ky. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Martha Dodd
MOTHER 15. Birthplace Lawrenceville, Ind. (City, town, or county) (State or foreign country)
16. (a) Informant E. A. Sudbrink
(b) Address 5617 Vernon Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12/45 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla
18. (a) Signature of funeral director Robert J. Ambruster
(b) Address Clayton Rd. at Concordia Lane
19. (a) MAY 12 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1945 hour 6 minute 30 P. M.
21. I hereby certify that I attended the deceased from 3/28/45 19 to 5/10/45 19; that I last saw her alive on 5/10/45 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Edema	7 days
Due to Chronic Myocarditis	
Chronic Interstitial Nephritis	
Due to Bronchial Asthma - Emphysema	
Other conditions (Include pregnancy within 3 months of death) 0	

Major findings:
Of operations No operation
Of autopsy No autopsy

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? Means of injury 0
23. Signature H. G. Henning (M. D. or Coroner)
Address 4548 Harris Avenue, Date signed 5/11/45

(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. 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.