7. S. No. 2
30M—5-43
ev. 5317.3
Form 1 X36671

FILED
SEP 1 1945

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26286

Primary Registration District No. 1003

Registrar's No. 7388

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

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:
5308 Theodosia Ave. 1
(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 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5308 Theodosia Ave. 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Agnes Wilson

3. (b) If veteran, name war Nil

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 William L. Wilson

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased December (Month) 22 (Day) 1874 (Year)

8. AGE: Years 70 Months 8 Days 1 If less than one day hr. min.

9. Birthplace Iuka (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Greenleaf Bell
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name Agnes Unknown
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country) 0

16. (a) Informant James L. Wilson
(b) Address 5308 Theodosia Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Tilden, Illinois

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 24 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23
year 1945 hour 8:15 minute P. M.

21. I hereby certify that I attended the deceased from 9-1- 1944, to 8-23- 1945
that I last saw h. alive on 8-23- 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	2 wks.
Due to Nephritis (Chronic) General Debility	17 yr 3 m.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 131
Of 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? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address 7532 Washington Date signed 8/24/45

(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 Albert J. Koppe

Licensed Embalmer No. 2971

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.