V. S. No. 2
00M—5-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32516

FILED OCT 19 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8776

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: Homer. G Phillips Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community (51) Fifty One YRs.
years, months or days)

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. 4316 Delmar Blvd.
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country U.S.A.

3. (a) PRINT FULL NAME Edieth A Wilson

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F & Male 3

5. Color or race Col

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

6. (b) Name of husband or wife Arthur Wilson

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

7. Birth date of deceased March (Month) 24 (Day) 1894 (Year)

8. AGE: Years 51 Months 6 Days ~~10~~ 13 If less than one day hr. min.

9. Birthplace ST. Louis (City, town, or county) MO. (State or foreign country)

10. Usual occupation Domestics.

11. Industry or business

FATHER
12. Name Grant Moore.
13. Birthplace Edwardsville (City, town, or county) Ill. (State or foreign country)

MOTHER
14. Maiden name Mary Trotter.
15. Birthplace (City, town, or county) KY. (State or foreign country)

16. (a) Informant Mary Moore
(b) Address 4316 Delmar. Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Cem.

18. (a) Signature of funeral director John H. Hampshill
(b) Address 408 S. Fillmore Ave Kirkwood Mo

19. (a) OCT 11 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7 year 1945 hour 10 minute 20 P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Patrick E. Taylor (M. D. or other)

Address Date signed 10/8/45

(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 Chas. L. Stowell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

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.