No. 2
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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. 38221

Registration District No. FILED NOV 18 1946

Primary Registration District No. 6076

Registrar's No. 3263

1. PLACE OF DEATH:

(a) County: ST LOUIS

(b) City or town: LEMAY MO
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: MT ST ROSE SANITARIUM
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 2 YEARS (Specify whether years, months or days)

In this community: 5 YEARS (NEE MARGARET WILSON)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: ST LOUIS 96

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

(d) Street No.: MT ST ROSE SANITARIUM
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: SISTER MARY MADONIA

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: F

5. Color or race: W

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: SEP (Month) 22 (Day) 1888 (Year)

8. AGE: Years 58 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace: QUINCY (City, town, or county) ILLINOIS (State or foreign country)

10. Usual occupation: SISTER IN RELIGION

11. Industry or business: SISTERS OF ST MARY

FATHER
12. Name: CHARLES WILSON
13. Birthplace: HANNIBAL (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name: MARY GOULD
15. Birthplace: MT STERLING (City, town, or county) ILL (State or foreign country)

16. (a) Informant: Sister Superior
(b) Address: 1100 Bellevue Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: NOV 11-1946 (Month) (Day) (Year)
(c) Place: burial or cremation: OLD ST PETER + PAUL

18. (a) Signature of funeral director: Watson Bogeaus
(b) Address: 6536 Clayton Rd

19. (a) 11-12-46 (Date received local registrar) (b) Ruth Allen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: NOV. day: 8 year: 1946 hour: minute: M.

21. I hereby certify that I attended the deceased from July 1946 to 11/9/46, 19; that I last saw her alive on 10/20/46, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Infarction — Duration

Due to: Arteriosclerosis

~~Due to~~: Diabetes Mellitus

Other conditions (Include pregnancy within 3 months of death): 61

Major findings:
Of operations: X
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: V. D. Mueller (M. D. or other)
Address: 6314 N. 22nd Date signed: 11/10/46

(Licensed Embalmer's Statement on Reverse Side)

A. Buckley

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 J. Allen Davis Jr

Licensed Embalmer No. 4053

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.