

No. 2  
12-35  
-17-39  
X47070

FILED JAN 27 1947

Primary Registration District No. **1002**

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

(d) Length of stay: In hospital or institution **2 days**  
(Specify whether in this community 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. **3960a Fairfax**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Margaret Dyson**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased **12 22 1939**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **13**  
year **1947** hour **4** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **1-11** 19**47**, to **1-13** 19**47**,  
that I last saw her alive on **Jan. 13** 19**47**  
and that death occurred on the date and hour stated above.

8. AGE: Years **54** Months **-** Days **27**  
If less than one day hr. min.

Immediate cause of death **Degenerative Heart Disease with De-**  
**compensation; Auricular Fibrillation**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace **St. Louis Mo**  
(City, town, or county) (State or foreign country)

Other conditions **None**  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy **No**

12. Name **Wilson Smith**  
13. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

14. Maiden name **Wilson Smith**  
15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dosha Burch**  
(b) Address **3868 Page I 20 47**

17. (a) **Burial** (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis Burial Cemetery**

18. (a) Signature of funeral director **J. A. Bredbeck**  
(b) Address **3129 Beigas ave**

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? \_\_\_\_\_

19. (a) **JAN 17 1947** (b) **J. A. Bredbeck**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **E. B. Williams** (M. D. or other) \_\_\_\_\_  
Address **2602 N Whittier** Date signed **1/14/47**

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**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.....

*E. Laet Young*

Licensed Embalmer No. *3371*

P. O. Address. *St Louis*

**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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

- (a) County ST. LOUIS
  - (b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)
  - (c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)
  - (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)
- In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Margaret Wyson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Dec 22 1891  
(Month) (Day) (Year)

8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_ (If rural, give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

2432

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