

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

11693

State File No. _____

Registration District No. _____ Primary Registration District No. _____

Registrar's No. 2698

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:
St. John's Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 Weeks
(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. 4424 Bircher Blvd
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Bertha M. Wickham

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1947 hour 6. minute 15. A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Edward C. Wickham

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased February 5 1880
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1/15/47
_____, 19____, to 3/13, 1947
that I last saw her alive on 3/12, 1947
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

67 1 8 hr. _____ min.

Immediate cause of death
Circulatory collapse Duration 2 hrs.

Due to Pneumonia 1 mo.

9. Birthplace Maryville, Mo.
(City, town, or county) (State or foreign country)

Due to Leyd Carcinomatosis 2 mos.

Other conditions Primary Biliary ducts, Intestinal divertic, hypertrophic arthritis lumbar.

10. Usual occupation Housewife

Major findings: Cal biliary duct system, metastases liver & ganglia

Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Theodore Jacobs

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

14. Maiden name Unknown

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

16. (a) Informant Henry Wickham

(b) Address 4237 N. Newstead Ave

17. (a) Burial (b) Date thereof Mar 15 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Calvin F Feutz

(b) Address 4828 Nat Bridge Blvd

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 _____

19. (a) Signature J. F. Brodeur (M. D. or other) _____

Address 2322 N. Smiggleway Date signed 3/23/47

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.....

John A. Milner

Licensed Embalmer No.....

4186

P. O. Address.....

St. Louis Mo

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.