

No. 2  
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5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15799**  
**4592**  
Registrar's No. \_\_\_\_\_

**FILED MAY 14 1947 318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4910 West Pine Blvd.,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 20 years  
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. 4910 West Pine Blvd.,  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Emma K. Wilson  
3. (c) Social Security name war. No. \_\_\_\_\_ No. None  
4. Sex F. / 5. Color or race W.  
6. (a) Single, widowed, married, Divorced W.  
6. (b) Name of husband or wife Joseph T. Wilson 6. (c) Age of husband or wife if 17 years  
7. Birth date of deceased April 17 1856  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 5  
year 1947 hour 1: minute 30 P. M.  
21. I hereby certify that I attended the deceased from October 1945 to 5 May 1947.  
that I last saw her alive on 5 May 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years 91 Months 0 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace Bird's Point, Mo. (City, town, or county) (State or foreign country)  
10. Usual occupation At Home  
11. Industry or business \_\_\_\_\_  
12. Name Geo. Kenrick  
13. Birthplace Ireland (City, town, or county) (State or foreign country)  
14. Maiden name Mary Rodney  
15. Birthplace Arkansas (City, town, or county) (State or foreign country)  
16. (a) Informant Lucille Lindsay  
(b) Address 325 N. Newstead  
17. (a) burial removal (b) Date thereof MAY 6 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Odd Fellows Cem. Charleston, Mo.  
18. (a) Signature of funeral director Alexander H. Bond  
(b) Address 16175 Delmar  
19. (a) MAY 6 1947 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

Immediate cause of death Cerebral hemorrhage  
Due to Essential hypertension and arteriosclerosis  
Due to \_\_\_\_\_  
Other conditions Carcinoma of bladder  
(Include pregnancy within 3 months of death)  
Major findings: Of operations 52 B  
Of autopsy \_\_\_\_\_  
Duration 3 hrs.  
several yrs.  
several yrs.  
15 mos.  
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 3  
23. Signature Truman J. Drake (M. D. or other) \_\_\_\_\_  
Address 114 N. Taylor, St. Louis 8 Date signed 16 May '47

Drake

1981 - 3 - NMF

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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.....  
*Thomas R. Senivick*

Licensed Embalmer No. *3793*

P. O. Address *6175 Delmar*

**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.**