

V. S. No. 300  
50M-10-47  
Rev. 5-17-39  
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1003

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED APR 3 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2598**

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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:  
De Paul Hospital  
(If not in hospital or institution, write street number or location)

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

3: (a) PRINT FULL NAME Wilhelmina Colgan

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

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

6. (b) Name of husband or wife Charles Colgan 6. (c) Age of husband or wife if alive 19 years 1872 (Day) (Year)

7. Birth date of deceased August 19 1872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 6 23 hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

12. Name William Fuller

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

14. Maiden name Ruth Britton

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

16. (a) Informant George Klein  
(b) Address 3957 Cottage Ave.

17. (a) Burial (b) Date thereof 3/15/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Stroot-Carroll  
(b) Address 4600 Natural Bridge Ave.

19. (a) MAR 16 1948 J. F. Br...  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3957 Cottage Ave.  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12  
year 1948 hour 6 minute 20 P M.

21. I hereby certify that I attended the deceased from 1942  
....., 19..... to March 12 1948  
that I last saw her alive on March 12 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death mesenteric Thrombosis

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death).....

Major findings: Of operations.....

Of autopsy Congestive bowel

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 William O. Moiray (M.D. or other).....  
Address 3625 Fair ave. (Date signed 3/15/48)

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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

*Ben Hoffman*  
.....  
Licensed Embalmer No. *4366*

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.**