

No. 300
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5-17-39
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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31536**
Registrar's No. **8381**

FILED OCT 9 1948 **318**
Registration District No.

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
(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. 21 days
(Specify whether years, months or days)

3: (a) PRINT FULL NAME Jewel Wilks

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex F 5. Color or race Negro

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 July 1929
(Month) (Day) (Year)

8. AGE: Years 19 Months 2 Days 21
If less than one day hr. min.

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

10. Usual occupation Typist

11. Industry or business.....

12. Name Robert Wilks

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

14. Maiden name Etta Couley

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

16. (a) Informant Martha Orton
(b) Address 4235a E. Page

17. (a) Burial (b) Date thereof 9/28/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney

19. (a) SEP 25 1948 (b) J. F. Breda
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ood

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

(d) Street No. 4235 a E Page
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24
year 1948 hour 7 minute 10 a. M.

21. I hereby certify that I attended the deceased from 8-3, 1948 to 9-24, 1948
that I last saw her alive on Sept. 24, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hodgkin's Disease
Duration Undet

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy None

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)
Means of injury.....

23. Signature Oscar L. Daniels (M. D. or other)
Address 7601 N. Whittier Date signed 9/24/48

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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 *John P. Cunningham*
Licensed Embalmer No. *41476*
P. O. Address *4107 4th Avenue*

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.