

318

1003

1332

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 12 yrs 10 mo 1 day		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 139 5800 Arsenal St.			

3. NAME OF DECEASED (Type or Print)		a. (First) Mary		b. (Middle) Elizabeth		c. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) Feb. 11, 1955		
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5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH June 5, 1886		9. AGE (In years last birthday) 68		10. F UNDER 1 YEAR Months 8 Days 6		11. F UNDER 4 HRS. Hours Mins. 	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Casey, Iowa				12. CITIZEN OF WHAT COUNTRY U S A	
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13a. FATHER'S NAME Jake Jager		13b. MOTHER'S MAIDEN NAME Lizzie ? (Unknown)			14. NAME OF HUSBAND OR WIFE Frank Wilson			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Margaret Willis 3634 Shenandoah Av.			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis							
		ANTECEDENT CAUSES DUE TO (b) Multiple sclerosis							
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 345X	
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22. I, hereby certify that I attended the deceased from April 21, 1942, to Feb. 11, 1955, that I last saw the deceased alive on Feb. 11, 1955, and that death occurred at 2:25A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Margaret Willis		23b. ADDRESS 5800 Arsenal St.		23c. DATE SIGNED 2-11-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-12-55		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. FEB 14 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Beiderwieden F.H. 1936 St. Louis Avenue	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 Student Embalmer No. working under my personal supervision. *Ant Embalmed*

Student
Signature of Student Embalmer

Signed *Norman J. Gehler*
General Director
Licensed Embalmer No.

P. O. Address *3620 Chippen*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.