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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

JAN 25 1941

Registration District No. 757

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 30 36

Dr. P.A. Schmitz

State File No. 43701

Registrar's No. 220

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1029 S. South St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) 2

8. (a) PRINT  
FULL NAME

James Earl Wilkins

8. (b) If veteran,

name war

No

8. (c) Social Security

No.

None

4. Sex

Male

5. Color or

race

White

6. (a) Single, widowed, married,

divorced

Married

6. (b) Name of husband or wife

Emma

6. (c) Age of husband or wife if

alive

48 years

7. Birth date of deceased

March 18 1885

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

55

9

5

hr.

min.

9. Birthplace

Boles

(City, town, or county)

Mo

(State or foreign country)

10. Usual occupation

Assistant Engineer

11. Industry or business

City Water Works, St. Charles

12. Name

Harvard Wilkins

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Martha James

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

Mrs. James L. Wilkins

(b) Address

1029 S. South St. - St. Charles, Mo

17. (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Dec. 26 - 1940

(Month) (Day) (Year)

(c) Place: burial or cremation

St. John's Cem. St. Charles

18. (a) Signature of funeral director

H. C. Ballmeyer & Sons

(b) Address

800 N. Second St. - St. Charles, Mo

19. (a)

1-10-41

(Date received local registrar)

(b)

Clarence S. Heister

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles  
(c) City or town St. Charles  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1029 S. South St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 23  
year 1940 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov 18  
1940, to Dec 23, 1940  
that I last saw him alive on Dec 23, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Hemiplegia

Duration

18 hrs

Due to

Arteriosclerosis

Due to

Ac

Other conditions

Ac Bronchitis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?  
10761  
While at work? \_\_\_\_\_ (Specify type of place)  
(f) Means of injury \_\_\_\_\_

23. Signature

Wm. A. Schmitz

(M. D. or other)

Address

St. Charles, Mo

Date signed

12/27/40

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

106a

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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 E. Dallmeyer*

Licensed Embalmer No. *9451*

P. O. Address *St Charles 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 43701

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 757

Primary Registration District No. 2036

Registrar's No.

1. PLACE OF DEATH:

- (a) County St Charles  
(b) City or town St Charles  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

James Earl Wilkins

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 9 5 h. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

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

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 23  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

- Immediate cause of death Pneumonia Duration \_\_\_\_\_

- Arterio sclerosis

- Due to \_\_\_\_\_

- Cerebral Hemorrhage -

- Due to \_\_\_\_\_

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

- Major findings: Of operations \_\_\_\_\_

- Of autopsy 520

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 Vincent A. Schneider (Date of death)

- Address St Charles Date signed \_\_\_\_\_

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

SUPPLEMENTAL

