

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15156

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *St. John*)

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **37883**
St. Ward

2. FULL NAME

Cenora J. Wilson

(a) Residence No. *249 Partridge* St. *12* Ward. *St. Louis Mo*

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 14 - 1879*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>47</i>	<i>7</i>	<i>5</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *mgr Cafeteria*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer *Boicott Kain School*

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Henry A Wilson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Eliz Campbell*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Mo*

14. INFORMANT *Louis J Wilson*
(Address) *249 Partridge Parmita Park*

15. FILED *15156* 19 *27* *Mar 6 Starceff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 19* 19 *27*

17. I HEREBY CERTIFY, That I attended deceased from *3/12/27*, 19... to *4/19/27*, 19... that I last saw h... alive on *4-15-27*, 19... and that death occurred, on the date stated above, at *8* *2* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hy perthermia
Exophthalmic
Goiter

CONTRIBUTORY (SECONDARY) *Exophthalmic*

18. WHERE WAS DISEASE CONTRACTED *Mo*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF... WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *W. J. Jack* M. D.
4/19/27 (Address) *Union Club Bldg*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Ann's Cem* DATE OF BURIAL *Apr 21* 19 *27*

20. UNDERTAKER *Thos J Finan* ADDRESS *4575 S Grand*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

