

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

Do not use this space.

29044

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No.....**791**
 Township.....*St. Louis*..... Primary Registration District No.....**1003**
 City.....*St. Louis* (No. *12169 Goodfellow*) St.*Goodfellow* Ward)

File No.....
 Registered No. **8528**

2. FULL NAME

Elizabeth Wilson

(a) Residence. No. *12169 Goodfellow St.* *5* Ward. (If nonresident give city or town and State)

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 (circle the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *James M. Wilson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 9 - 1874*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
85 | *3* | *17*

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *At Home*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *Charles Goddard*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Mrs. M. M.*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. Informant (Address) *Elizabeth Wilson 12169 Goodfellow St. St. Louis*

15. FILED *Mar. 6 1919* Registrar *Max C. Clarke*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 26 1917*
 17.

I HEREBY CERTIFY, That I attended deceased from *Sept 10*, 19*17*, to *Sept 22*, 19*17*, that I last saw him alive on *Sept 21*, 19*17*, and that death occurred, on the date stated above, at *3 40 p.m.*

THE CAUSE OF DEATH;* WAS AS FOLLOWS:
Cerebral Hemorrhage - Apoplexy 92A
 (duration)..... yrs. mos. *16* ds.
 CONTRIBUTORY (SECONDARY) *140A*
 (duration)..... yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY..... *no*
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *W. Brown* M. D.
 , 19 (Address) *Wald 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 *Rest Bud Bld. St. Louis* DATE OF BURIAL *Sept 27 1917*
 20. URBERTAKER *W. H. Stewart* ADDRESS *5525 Eastern Dr.*

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.

DEATH RECORD

H. W. ...
Wad. Bldg