

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

Do not use this space.

20165
5834

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... **Solonia**

(No. **1820** **Nebraska Ave.**)

File No.....

Registered No.....

St. Ward)

2. FULL NAME

(a) Residence. No. **1820 Nebraska** St., **223** 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** **widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 10 - 1854**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
74 11 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housework**
(b) General nature of industry, business, or establishment in which employed (or employer) **at Home**
(c) Name of employer

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

10. NAME OF FATHER **Geo. W. Wilkinson**

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

12. MAIDEN NAME OF MOTHER **Edna Carter**

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

14. INFORMANT **George F. Jatum**
(Address) **1820 Nebraska Ave**

15. FILED **MAY 27 1929** **W. C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25 1929**

17. I HEREBY CERTIFY, That I attended deceased from **June 10 1928**, to **May 25 1929**, and that I last saw her alive on **May 25 1929**, and that death occurred, on the date stated above, at **10 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
922
1118

(duration) **3** yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Oedema of Lungs**
(duration) yrs. mos. **4** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) **W. H. Samuel**, M. D.
May 27 1929 (Address) **1460 So Grand Ave**

*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 **Bellefontaine Cemetery** **DATE OF BURIAL** **May 28 1929**

20. UMBERTAKER **Peetz Bros. 302 1/2 Lafayette Ave** **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD--
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.

2-26-29

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