

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.

1939

REC'D MAR 9 1939

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

7741
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
(b) Township Clayton Primary Registration District No. 01 Registered No. 377
(c) City Clayton (d) Street No. St. Louis County Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kate Wilson

(a) Residence, No. 1554 Wellston Pl., Wellston, Mo. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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) June 22, 1886

7. AGE YEARS 52 MONTHS 8 DAYS 7 If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housework
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

FATHER 13. NAME Mose Wilson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

MOTHER 15. MAIDEN NAME Eliza Johnston

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

17. INFORMANT nephew, R.C. Leuter (ADDRESS) 1554 Wellston Pl., Wellston,

18. BURIAL, CREMATION, OR REMOVAL PLACE Rector Ark. DATE 3/5/39.

19. FUNERAL DIRECTOR (NAME) Jos W Clark (ADDRESS) 1125 Abbeumont Ave, St. Louis

20. FILED MAR 1 1939 R. Meyer, M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/1/39 19

22. I HEREBY CERTIFY, That I attended deceased from 2/23/39, 19, to 3/1/39, 19.

I last saw her alive on 3/1/39, 19. Death is said to have occurred on the date stated above, at 5:45 A.M.
The principal cause of death and related causes of importance were as follows:

Acute nephritis (appx) 2/1-39

Other contributory causes of importance:
Coronary Renal Vasculer (?)
disease

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____ (Signed) George M. Lusk, M. D.
(Address) 70 St Louis Co Hosp

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.....

A. J. Kelly
.....
Licensed Embalmer No. *3225*

P. O. Address *238 Lucas Hunt Rd*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.