

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 1533

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town Richmond Heights  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St Marks Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 DAYS  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1  
(c) City or town Cuba  
(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.

8. (a) PRINT FULL NAME Irvin Wilkie 420  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 28  
year 1939 hour 1205 minute 00 M.  
21. I hereby certify that I attended the deceased from 8/23/39 19\_\_\_\_ to 8/28/39 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Minnie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept. 25 1863  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Due to Malignant ulcer of stomach  
Due to \_\_\_\_\_  
Other conditions Arteriosclerosis, Hypertension, Diabetes, Schmorl's  
(Include pregnancy within 3 months of death)

8. AGE: Years 75 Months 11 Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation 1

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

MOTHER FATHER  
12. Name James D Wilke 9  
13. Birthplace Unk. 7  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth Chambers  
15. Birthplace Unk.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Minnie Wilkie  
(b) Address Cuba Mo

17. (a) Burial (b) Date thereof 8-28-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cuba Mo

18. (a) Signature of funeral director Hollas of unese home  
(b) Address 829-34

19. (a) 8-29-39 (b) DR. M. W. ...  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_  
28. Signature W. Falk (M. D. or other) \_\_\_\_\_  
Address 3604 Washington Date signed \_\_\_\_\_

**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 *Howard G. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St. Louis*

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

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