

7. S. No. 2
 OM-5-42
 Rev. 5-17-39
 X32873

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

39500

FILED DEC 29 1942 318 STANDARD CERTIFICATE OF DEATH 1003

State File No. _____

Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Rose Wilson
 3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced, Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Aug. 5th 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 4 10 hr. _____ min.

9. Birthplace: Washington County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation: Housemaid

11. Industry or business _____

MOTHER FATHER { 12. Name Reuben Wilson
 13. Birthplace Unknown Georgia
(City, town, or county) (State or foreign country)
 14. Maiden name Amanda Green
 15. Birthplace Unknown, Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cinda Schmalzreed
 (b) Address 4943 Lexington Ave.

17. (a) Burial (b) Date thereof 12-17-42
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Bismarck, Mo.

18. (a) Signature of funeral director Albert E. Hoppe Inc.
 (b) Address 4700 Washington Blvd.

19. (a) DEC 29 1942 (b) J. J. Prudech
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
 (c) City or town Bismarck
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15th
 year 1942 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from August 4, 1942, to December 15, 1942, that I last saw her alive on December 15, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of pancreas

Due to _____
 Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of pancreas
 Of operations: _____
 Of autopsy: Carcinoma of pancreas.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) XXXXXXXXXX
 (b) Date of occurrence XXXXXXXXXX
 (c) Where did injury occur? XXXXXXXXXX
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? XXXXXXXXXX

While at work? XXXXXXXXXX (Specify type of place) _____
(If means of injury)

23. Signature [Signature]
 Address 812 Olive St. Date signed 12/17/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

The Acc Rendelman
Sir Oliver

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..... *Albert G. Hoffe*
Licensed Embalmer No..... *2971*
P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.