

S. No. 2  
M-2-43  
5-17-39  
I X3987

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40742  
State File No. \_\_\_\_\_  
Registrar's No. 11243

FILED DEC 29 1943  
318  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

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

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:  
6433 Odell Av  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6433 Odell Av.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Agnes C. Wilcox  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 220.  
4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Roland Wilcox 6. (c) Age of husband or wife if alive 56 years  
7. Birth date of deceased Sept. 19 1891  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 13  
year 1943 hour 11 minute 20 p.m.  
21. I hereby certify that I attended the deceased from Dec. 8, 1943, to Dec 14, 1943  
that I last saw him alive on Dec 14, 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
52 2 24 hr. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace St. Louis Mo. 0  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Immediate cause of death Virus pneumonia Duration 6 days  
Due to Influenza  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 5/7

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Unknown Grill  
13. Birthplace Bohemia 8  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Bohemia 6  
(City, town, or county) (State or foreign country)  
16. (a) Informant Roland Wilcox  
(b) Address 6433 Odell Av.  
17. (a) Burial (b) Date thereof 12-17-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation S.S. Peter + Paul Cem.  
18. (a) Signature of funeral director Wm. Bro. & Co.  
(b) Address 2929 S. Jefferson Av.  
19. (a) DEC 16 1943 (b) J. F. Boehlke  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
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 \_\_\_\_\_  
23. Signature Dr. L. Feldman (M. D. or other) D.O.  
Address 4468 Delmar Blvd Date signed 12/15/43

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**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, *Gustav W. Dieterle*

Licensed Embalmer No. *4329*

P. O. Address... *2929 S. Jefferson*

**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.**