

FILED FEB 4 1948

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3182 S. Compton
 (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 Missouri (b) County 17
 (c) City or town St. Louis 9
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3182 S. Compton Ave.
 (If rural, give location) 16
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Anna Frances Wilson

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife Lester Wilson 6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased May 1 1893
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 8 25 _____ hr. _____ min.

9. Birthplace Macon County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Francis A. Quinn
 13. Birthplace County Mayo Ireland
 (City, town, or county) (State or foreign country)
 14. Maiden name Marie Evelyn Tuite
 15. Birthplace Unknown New York
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Melvin Hite
 (b) Address Ferndale, Michigan.
 17. (a) Burial (b) Date thereof 1-29-44
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Brookfield, Mo.

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

19. (a) JAN 28 1944 (Date received local registrar) J. F. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 26
 year 1944 hour 1.55 minute P. M.

21. I hereby certify that I attended the deceased from Jan 24, 1944 to Jan 28, 1944
 that I last saw her alive on Jan 27, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 1-28-44

Due to arterio-sclerosis - cerebral

Due to giga

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none made

Of autopsy none made

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) no
 (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? _____

23. Signature W. S. [Signature] (M. D. or other) MD
 Address 3318 S. Grand Date signed _____

MAR 1 3 1944

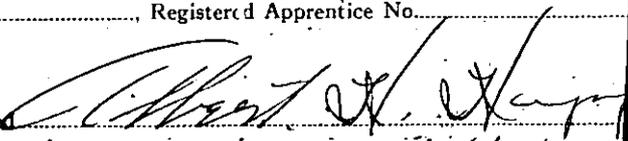
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No.....

1861

P. O. Address.....

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, fact should be so stated above.