

No. 2
-2-43
17-39
X555

FILED MAY 29 1944

State File No. _____

Registration District No. _____

Primary Registration District No. 5655

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 690 days
(Specify whether
In this community 690 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis County
(c) City or town 2215 Richert Ave, St. Louis, Mo
(If outside city or town limits, write "RURAL") 000
(d) Street No. _____ (If rural, give location) 17
(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th
year 1944 hour 11:40 minute _____ A. M.

21. I hereby certify that I attended the deceased from June 27th 1942 to May 18th 1944
that I last saw her alive on May 18th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis, abt 5 yrs

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 13 fl

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)
(c) Means of injury _____
23. Signature Esther E. Cuffman (M.D.)
Address Mount Vernon Mo Date signed 5-18-44

Duration abt 5 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Margaret Chilton Wolfe

3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Not known 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased: Feb. (Month) 5th (Day) 1906 (Year)

8. AGE: Years 38 Months 3 Days 13 If less than one day hr. _____ min.

9. Birthplace: Glencoe (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles Williams

13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

14. Maiden name Amelia Bruer

15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State Sanatorium, Mt. Vernon

17. (a) Removal (b) Date thereof 5/19/44
(c) Place: burial or cremation NO

18. (a) Signature of funeral director Geo B Orr
(b) Address Home Mt. Vernon Mo

19. (a) 5/20 (b) _____ (c) _____
(d) _____ (e) _____
(f) _____ (g) _____
(h) _____ (i) _____
(j) _____ (k) _____
(l) _____ (m) _____
(n) _____ (o) _____
(p) _____ (q) _____
(r) _____ (s) _____
(t) _____ (u) _____
(v) _____ (w) _____
(x) _____ (y) _____
(z) _____

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,
District File Number 544-653
Date Filed MAY 24 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. 946

P. O. Address. 7th Yermion

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.