

STANDARD CERTIFICATE OF DEATH

21296

State File No.

Registrar's No.

FILED JUN 24 1946
Registration District No. 317

Primary Registration District No. 3063

1292

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

1. PLACE OF DEATH:
 (a) County St. Louis County
 (b) City or town Clayton, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 days
4 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis 96
 (c) City or town Clayton 2
(If outside city or town limits, write "RURAL")
 (d) Street No. 7710 Bonhomme Ave. 3
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No) 0
 If yes, name country _____

3. (a) PRINT FULL NAME SUSIE WILKINSON
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 13th
 year 1946 hour 4 minute 48 A. M.

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Gale Wilkinson 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased December 15, 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1,
1946 to June 13, 1946
 that I last saw her alive on June 13, 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>5</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death Encephalitis Duration _____

9. Birthplace Westpoint Mississippi
(City, town, or county) (State or foreign country)

Due to extension of otitis media
 Due to 89 a

10. Usual occupation Housewife

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

11. Industry or business _____

MOTHER, FATHER {
 12. Name Thomas Hampton
 13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name Lou ?
 15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

Major findings:
 Of operations increased intracranial pressure.
 Of autopsy _____
 PHYSICIAN: _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Gale Wilkinson
 (b) Address 7710 Bonhomme Ave.

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

17. (a) Burial (b) Date thereof 6-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Father Dickson

While at work? _____
(Specify type of place) (e) Means of injury

18. (a) Signature of funeral director J. Lewis
 (b) Address 27 Euclid St. Webster Groves
 19. (a) 6-15-46 (b) E. S. McFarlane
(Date received local registrar) (Registrar's signature)

23. Signature H. Zantz, M.D. (M. D. or other) _____
 Address 601 Brentwood Blvd. Date signed 6-14-46

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.....

J. D. Lewis

Licensed Embalmer No.

2027

P. O. Address.....

Theater House

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.