S. No. 2
M—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 24 1946 318

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32349

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8008

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Imfirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5/7/46 to 9/14/46 (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 19 or 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3930 Westminster Pl. 90
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME ANNA WILSON

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec (Month) 27 (Day) 1879 (Year)

8. AGE: Years 66 Months 8 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Nil.

11. Industry or business _____

FATHER
12. Name James Mace
13. Birthplace Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal St.

17. (a) BURIAL (Burial, ~~cremation, or~~ removal) (b) Date thereof Sept 17-46 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ MARION ILLINOIS

18. (a) Signature of funeral director X Schurr E. J.
(b) Address 3125 Lafayette Av.

19. (a) SEP 17 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14 year 1946 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from 10/18, 1945 to Sept. 14, 1946 that I last saw her alive on September 14, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of colon, metastatic	3 yrs
Due to _____	
Due to _____	
Other conditions (Include pregnancy within 3 months of death)	

46

Major findings:
Of operations _____
Of autopsy Carcinoma of colon - metastases to liver & lung

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

23. Signature John E. Helm, M.D. (M. D. or other)
Address 5800 Arsenal Date signed 9/25/46

(Licensed Embalmer's Statement on Reverse Side)

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 Joe B. Vollmer

Licensed Embalmer No. 4014

P. O. Address St. Louis Mo

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.