

No. 2  
12-45  
17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED NOV 17 1946**  
Registration District No. 3 17

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

388320  
State File No. \_\_\_\_\_  
Registrar's No. 3259

Primary Registration District No. 6076

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

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis, Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
ROBERT KOCH HOSP. KOCH MO.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 37 days  
45 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME ELIZABETH F. WILSON  
3. (b) If veteran, name war No  
3. (c) Social Security No. yes

4. Sex Female 5. Color or race colored  
6. (a) Single, widowed, married, divorced, separated  
6. (b) Name of husband or wife ELROY WILSON  
6. (c) Age of husband or wife if alive 2 years  
7. Birth date of deceased 7 - 9 - 1894  
(Month) (Day) (Year)

8. AGE: Years 52 Months 3 Days 25  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation MAID

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name BUD WALKER  
13. Birthplace MO.  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH TURNER  
15. Birthplace MO.  
(City, town, or county) (State or foreign country)

16. (a) Informant KOCH HOSPITAL RECORD  
(b) Address KOCH MO.

17. (a) Burial (b) Date thereof 11/9/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery  
Ellis Funeral Home  
18. (a) Signature of funeral director 2820 Stoddard St.  
(b) Address

19. (a) 11-9-46 (b) Ruth Allen  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County St. Louis  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2713 DELMAR 9  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 11 day 3  
year 46 hour 6 minute 25 A.M.  
21. I hereby certify that I attended the deceased from 9-27  
1946 to 11-3 1946  
that I last saw her alive on 11-3 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Pulmonary Tuberculosis 9 mo.?  
Due to \_\_\_\_\_  
Due to 13\*  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy (none done)  
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?

23. Signature Ruth Allen (M. D. or other) my  
Address Koch Mo. Date signed 11-3-46

**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 L. B. B...  
....., Registered Apprentice No. SM  
working under my personal supervision.

Signed Lomnie Boufford  
Licensed Embalmer No. 52946  
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.**