

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26219**
Registrar's No. **6616**

FILED JUL 21 1947
Registration District No. **318**

Primary Registration District No. **1003**

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

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:
2827 Clark
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 2 years
years, months or days

3. (a) PRINT FULL NAME Della Wilson

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug. 29 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

40	10	12	hr. min.
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9. Birthplace Mississippi
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name 2 Silas

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

14. Maiden name Unknown

15. Birthplace "
(City, town, or county) (State or foreign country)

16. (a) Informant Callie Brown

(b) Address 2827 Clark

17. (a) Burial (b) Date thereof 7/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Dement & Son

(b) Address 2620-31 Cole

19. (a) Jul 14 1947 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad

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

(d) Street No. 2827 Clark
22 (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
year 1947 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 4
1947 to July 11
1947 that I last saw er alive on July 10
1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Duration 5 days

Due to mitial Incomptency

Duration 6 mo

Other conditions (Include pregnancy within 3 months of death) 92

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 9

23. Signature J. S. Jaques (M. D. or other) _____
J. S. Jaques Date signed 7/14/47

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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 W. Claude Gordon

Licensed Embalmer No. 3484

P. O. Address 4575 Aldine

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.