

No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 11 1947 318
Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003
Primary Registration District No.

State File No. **33159**
9213
Registrar's No.

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **MISSOURI PACIFIC HOSP**
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution..... **10 DAYS**
(Specify whether
In this community..... **17 YEARS**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... **MISSOURI** (b) County..... **ST. LOUIS 96**
(c) City or town..... **JENNINGS**
(If outside city or town limits, write "RURAL")
(d) Street No. **5737 HIGGINS DR**
W.R. (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... **Mrs. Augusta Wilson**
3. (b) If veteran, name war.....
3. (c) Social Security No.
4. Sex..... **F** 5. Color or race..... **W** 6. (a) Single, widowed, married, divorced..... **MARRIED**
6. (b) Name of husband or wife..... **EDWARD WILSON** 6. (c) Age of husband or wife if alive..... **57** years
7. Birth date of deceased..... **AUG - 28 - 1885**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month..... **Oct** day..... **2**
year..... **1947** hour..... **5** minute..... **30 AM** M.
21. I hereby certify that I attended the deceased from..... **Sept 22**
22, 1947 to..... **Oct 2**, 1947
that I last saw her alive on..... **Oct 1**, 1947
and that death occurred on the date and hour stated above. Duration

Immediate cause of death..... **Atherosclerotic heart disease**
Due to.....
Due to.....
Other conditions.....
(include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN
Underline the cause of which death should be charged statistically.

8. AGE: Years Months Days If less than one day
62 **1** **4** hr..... min.
9. Birthplace..... **SALISBURY - MD**
(City, town, or county) (State or foreign country)
10. Usual occupation..... **HOUSEWIFE**
11. Industry or business.....
12. Name..... **JACOB EDELMAN**
13. Birthplace..... **UNKNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name..... **UNKNOWN**
15. Birthplace..... **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Mr. Edward Wilson**
(b) Address..... **5737 Higgins Dr**
17. (a) **BURIAL** (b) Date thereof..... **10-6-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **MEMORIAL PARK CEM**
18. (a) Signature of funeral director..... **F. B. Tanner**
(b) Address..... **6107 Natural Bridge Rd**
19. (a) **OCT 4 1947** (b) **J. F. Buelck**
(Date received local registrar's report) (Registrar's signature)

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)
Means of injury.....
Signature..... **Vincent J. Eusebio** (M. D. or D.O.)
Mo Pac Hosp Date signed..... **2 Oct 47**

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

MOTHER FATHER

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. *4053*.....

P. O. Address..... *St. Francis, 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.