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5-17-39  
P1 X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36428

State File No. \_\_\_\_\_

FILED OCT 24 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9330**

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:  
St. Anthony Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 56 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County aaa

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

(d) Street No. 3919 Schiller Pl.  
15  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence F. 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 Albert R.

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased April 8 1900  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>5</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation At Home

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

12. Name John P. Barry

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

14. Maiden name Catherine Brady

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

16. (a) Informant Albert R. Wilson

(b) Address 3919 Schiller Pl.

17. (a) Removal (b) Date thereof 10/9/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newport Kentucky

18. (a) Signature of funeral director Gebken-Benz Mortuary

(b) Address 2842 Meramec St.

19. (a) OCT 8 1947 (b) J. J. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th  
year 1947 hour 9 minute 35 P. M.

21. I hereby certify that I attended the deceased from 11 Aug 1947 to 7 October 1947  
that I last saw her alive on 7 October 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Patal Carcinosis Duration 4 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 12/4

Major findings: Of operations \_\_\_\_\_

Of autopsy Yes

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

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no  
(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 no

23. Signature Earl J. Bierl (M. D. or other) \_\_\_\_\_

Address 508 N. Grand Date signed 8 Oct 47

(Licensed Embalmer's Statement on Reverse Side) Earl J Bierl

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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..... me.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Loren E. Percy

Licensed Embalmer No. 4094

P. O. Address 2842 Meramec St  
St. Louis, 18 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.**