

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

National Office of Vital Statistics  
**FILED MAY 7 1948**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4075**

**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:  
City Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Month 13 days.  
(Specify whether 11 years. years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County noo

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

(d) Street No. 1329a South Vandeventer Ave.  
(If rural, give location)

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

If yes, name country.....

**3. (a) PRINT FULL NAME** WIGGINS, MOLLIE FORREST.

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, Widow.

6. (b) Name of husband or wife Fred Wiggins.

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

7. Birth date of deceased July 7th; 1864  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>83</u>	<u>9</u>	<u>8</u>	.....br. ....min.

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

10. Usual occupation House -Wife.

11. Industry or business.....

12. Name Granville McCarthy

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

14. Maiden name Belvne Huitt.

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

16. (a) Informant City Infirmary Records.

(b) Address 5800 Arsenal St.

17. (a) Anatomical Board (b) Date there APR 30 1948  
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of informant Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) APR 30 1948 (b) J. F. Prudeck  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 15th;  
year 1948 hour 11:35 P. minute M.

21. I hereby certify that I attended the deceased from March 2nd;  
19 48 to April 15th; 19 48  
that I last saw her alive on April 15th; 19 48.  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure -  
Few Minutes.

Due to Hypertrophic Arthritis -  
Arteriosclerotic heart disease

Due to Hypertension 1947 Plus

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

Major findings:  
Of operations.....

Of autopsy.....

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 Palma Puanne Rowland (M. D. or other)

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.