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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 21 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

38809
State File No. 9847
Registrar's No.

Registration District No. 318

Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether _____)
In this community 19 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County Ripley 9/3
(c) City or town DOHLEPHAN
(If outside city or town limits, write "RURAL")
(d) Street No. RFD No 1
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wilson, Ida M.
(b) If veteran, name war None
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 8
year 1948 hour 12:05 minute _____ A M.
21. I hereby certify that I attended the deceased from Nov 3, 19 48 to Nov. 8, 19 48
that I last saw her alive on NOV. 8, 19 48
and that death occurred on the date and hour stated above.

4. Sex Female / race White / 5. Color or race _____
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife W. Wilson / (c) Age of husband or wife if alive 71 years
7. Birth date of deceased: _____
(Month) (Day) (Year)

Immediate cause of death _____
Coronary occlusion
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

8. AGE: Years 67 Months 1 Days 7 If less than one day _____ hr. _____ min.
9. Birthplace Kirkwood Illinois
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy As above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation Housewife
11. Industry or business _____
12. Name John Irine
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Lin Kawa
15. Birthplace W. & W. Unknown
(City, town, or county) (State or foreign country)
16. (a) Informant W. J. Wilson
(b) Address Lindsay Calif
17. (a) Remove (b) Date thereof 11-8-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dohlephan Mo
18. (a) Signature of funeral director Rowland Mortuary Service
(b) Address NOV 13 1948 104 Manchester Ave
19. (a) _____ (b) J. B. Rasater
(Date received local registrar) (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) (e) Means of injury _____
23. Signature H. Bradley (M. D. or other) _____
Address Barnes Hospital, Date signed 11/8/48

9847

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.....

J. Allen Davis Jr
Licensed Embalmer No. *4053*

P. O. Address *M. Lane*

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.