

FILED SEP 21 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32083

State File No.

BIRTH NO. _____ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 2068 Registrar's No. 3127

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Maplewood</u>	c. LENGTH OF STAY (In this place) <u>25 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Maplewood</u>	d. STREET ADDRESS (If rural, give location) <u>2626 Hope</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2626 Hope</u>		d. STREET ADDRESS (If rural, give location) <u>2626 Hope</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Martha</u>	b. (Middle) <u>Amanda</u>	c. (Last) <u>WILSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 11 1951</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1971</u> <u>March 24 1888</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of applicable years, even if retired) <u>Housewife.</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John Davidson</u>	13b. MOTHER'S MAIDEN NAME <u>Dollie Stearns</u>	14. NAME OF HUSBAND OR WIFE <u>Charles A Wilson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs R.G. May</u>	ADDRESS <u>2626 Hope</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>many years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis, left</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis, generalized and Hypertension.</u> DUE TO (c) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 4-16, 1951 to 9-7, 1951, that I last saw the deceased alive on 9-7, 1951, and that death occurred at 12:20 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul T. Garger, M.D.</u>	23b. ADDRESS <u>07158 Manchester, St. Louis</u>	23c. DATE SIGNED <u>9-12-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>Sept 13 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>
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DATE REC'D BY LOCAL REG. <u>9-12-51</u>	REGISTRAR'S SIGNATURE <u>Robert P. Tombe MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schnur</u>	ADDRESS <u>3125 Lafayette</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *J. B. Ballmer*

Licensed Embalmer No. 4014

P. O. Address 3125 Lakewood

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.