V.S. No. 200
Rev. 10.48

FILED APR 25 1952

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 14925

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3476

**1. PLACE OF DEATH**
a. COUNTY: 0
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): De Paul Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: 2069
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 4828 Ashland Ave.

**3. NAME OF DECEASED** (Type or Print)
a. (First): Anna
b. (Middle): M.
c. (Last): Wilkinson

**4. DATE OF DEATH** (Month) (Day) (Year): Apr. 11 1952

**5. SEX**: female
**6. COLOR OR RACE**: white
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): married
**8. DATE OF BIRTH**: Nov. 8 1878
**9. AGE** (In years last birthday): 73 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: Home
**11. BIRTHPLACE** (City and State or Foreign Country): Hesker Ill.
**12. CITIZEN OF WHAT COUNTRY?**
**13a. FATHER'S NAME**: Joseph Henkel
**13b. MOTHER'S MAIDEN NAME**: Wilhelmina Hesker
**14. NAME OF HUSBAND OR WIFE**: Leslie M. Wilkinson
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service)
**16. SOCIAL SECURITY NO.**
**17. INFORMANT'S SIGNATURE OR NAME — ADDRESS**: Leslie Wilkinson, 4828 Ashland

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy — Interval between onset and death: 9 days

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Hypertension — 5 years

DUE TO (c) Cerebral Sclerosis — 5 years

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 ☐ NO ☐

**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)
**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?** 33 c/x

22. *I hereby certify that I attended the deceased from* 4/1, 19 52, *to* 4/11, 19 52; *that I last saw the deceased alive on* 4/11, 19 52, *and that death occurred at* 11:30p m., *from the causes and on the date stated above.*

**23a. SIGNATURE** Theodore Greiner, M.D. (Degree or title)
**23b. ADDRESS** 4500 Olive St.
**23c. DATE SIGNED** 4/12/52

**24a. BURIAL, CREMATION, REMOVAL** (Specify): removal
**24b. DATE**: 4/14/52
**24c. NAME OF CEMETERY OR CREMATORY**: Valhalla Cemetery
**24d. LOCATION** (City, town, or county) (State): St. Louis Co. Mo.

DATE REC'D BY LOCAL REG.: APR 15 1952
REGISTRAR'S SIGNATURE: J. Carl Smith M.D.
**25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS**: Drehmann-Harral, 1905 Union Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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

497

Dr. Theo Greiner,
4500 Olive St.,
(1 to 3)

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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 _____, Student Embalmer No. _____, working under my personal supervision.

Student .....
Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 3534

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.