

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34314**
Registrar's No. **9327**

FILED OCT 15 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS, MISSOURI		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) 4402 Mc Pherson	

3. NAME OF DECEASED (Type or Print)	a. (First) Meta	b. (Middle) Marie	c. (Last) WILKINSON	4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 25, 1887	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Newton, Kansas		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Martin Mankowski.	13b. MOTHER'S MAIDEN NAME Helena unk	14. NAME OF HUSBAND OR WIFE Drane Wilkinson.
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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) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Drane Wilkinson, 4402 McPherson	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral vascular collapse		DUE TO (b) Cerebral vascular accident		48 hours
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)		4 days
II. OTHER SIGNIFICANT CONDITIONS Cortical atrophy w/psychosis and convulsions		Conditions contributing to the death but not related to the disease or condition causing death.		3 years

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X

22. I hereby certify that I attended the deceased from **9/22**, 19 **53**, to **9/27**, 19 **53**, that I last saw the deceased alive on **9/27**, 19 **53**, and that death occurred at **2:20a.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) FR Bradley M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 9/27/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-30-1953	24c. NAME OF CEMETERY OR CREMATORY Valhalla	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. SEP 28 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons	ADDRESS 7233 Delmar Blvd
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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.....
Signature of Student Embalmer

Signed *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.