

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015957

STATE FILE NUMBER

2-4354

FILED MAY 15 1959

Registration District No. _____ Primary Registration District No. _____

300
1-57
32
BK
93

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kirkwood, Mo. 4780
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.		Length of stay in lb ---	d. STREET ADDRESS (If outside, give location) #9 Lamertin
3. NAME OF DECEASED (Type or print) First Middle Last MARIE -- .WILKINSON.			4. DATE OF DEATH Month Day Year May 2, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY -- none	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 65 Months 4 Days 1 Hours Min.
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm. Booth		13b. MOTHER'S MAIDEN NAME Catherine O'Connell	14. NAME OF HUSBAND OR WIFE W.D. Wilkinson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If <input checked="" type="checkbox"/> , give war or dates of service) none		16. SOCIAL SECURITY NO. None	17. INFORMANT Address W.D. Wilkinson, 9 Lamertin, Kirkwood (22) Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia + aphasia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Embolus from surgical appendec</u> DUE TO (c) <u>Auricular fibrillation + arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous left hemiplegia, Osteoporosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>6 weeks</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 433.1		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>January 1945</u> to <u>5-2-59</u> and last saw her alive on <u>5-2-59</u> Death occurred at <u>St. Lukes Hospital</u> <u>4 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Keith S. Wilson</u> (Degree or title) M.D.		22b. ADDRESS <u>4952 Maryland Ave</u>	22c. DATE SIGNED <u>5-4-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE <u>5/4/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>C.R. Lupton & Sons, 7233 Delmar</u>		25. DATE RECD. BY LOCAL REC. <u>MAY 4 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

g.p.

12:5 P. M. Mon.
1:30 To 3:00 P. M.

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, Mo*

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.