

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791
1003876
Do not use this space.

876

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No.....
 (c) City St. Louis, Mo. (d) Street No. Saint Louis Maternity Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

425
Wilson, Infant by
 (a) Residence, No. 1963 Alfred Avenue St. 17
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 4:05pm
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 22, 1939
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
Stillborn

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

FATHER
13. NAME Hunt Price Wilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Cty. Mo.

MOTHER
15. MAIDEN NAME Garnett Mozell Adams
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fairmount, Ind.

17. INFORMANT (ADDRESS) Hunt Price Wilson
1963 Alfred Ave

18. BURIAL, CREMATION, OR REMOVAL
PLACE Wash. Univ **DATE** 1-28 1939

19. FUNERAL DIRECTOR (ADDRESS) Dept. of Pathology
1100 Grand

20. FILED JAN 28 1939
J. F. DeLoach
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 22 1939

22. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:05 m.

The principal cause of death and related causes of importance were as follows:

macerated stillborn 26 gestation.

Other contributory causes of importance:

Premature separation of Placenta.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Melina A. Robie 1, M. D.

(Address) 3720 Washington

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STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)