

REC'D NOV 13 1939

1008

Primary Registration District No. _____

Registrar's No. 8621

1. PLACE OF DEATH: ST LOUIS
 (a) County 1
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution HOMER PHILLIPS HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME GEAL WILSON 125
 (b) If veteran, name war _____ (c) Social Security No. none

4. Sex F. 5. Color or race col 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife WALTER WILSON 6. (c) Age of husband or wife if alive 32 years
 7. Birth date of deceased Dec. - 27 - 1908
 (Month) (Day) (Year)

8. AGE: Years 31 Months 4 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Unknown La.
 (City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business none

MOTHER FATHER
 12. Name Unknown
 13. Birthplace Unknown La.
 (City, town, or county) (State or foreign country)
 14. Maiden name Hannah Holmes
 15. Birthplace Unknown La.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter Wilson
 (b) Address 1125 no 8th Street

17. (a) Burial (b) Date thereof 10-10-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Metropolitan Funeral Home
 (b) Address 3038 Dickson St.

19. (a) OCT 9 1939 (b) J. P. Brubaker
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St Louis 25
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1125 no 8th Street
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th
 year 1939 hour 11:30 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy;
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 9 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature Joseph M. Levens (Specify type of place) _____
 while at work? _____ Means of injury _____

23. Signature Deputy Registrar (M. D. or other) _____
 Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *Arthur L. Williams*

Licensed Embalmer No. 3389

P. O. Address 3028 Dickson

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

34083

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
 (b) Township St Louis..... Primary Registration District No. 1003 Registered No. 8621
 (c) City St Louis..... (d) Street No.
 (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ceal Wilson
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Mar

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 27 1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 9 7

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)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 7/2/40 19..... J. B. Bideck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 4 1937

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

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at.....m.

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

Date of onset

Other contributory causes of importance:

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)....., M. D.

(Address).....

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

