

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.

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
38 years (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3711 McDonald
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

8. (a) PRINT FULL NAME Charles T. Wilson

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife WIFE Wilson, LUTIE 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased June 3, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 7 26 hr. min.

9. Birthplace Borgtown- Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation City Hall

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Wilson

13. Birthplace Borgtown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Raechael Tucker

15. Birthplace Borgtown Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Catherine Wilson
(b) Address 3711 McDonald

17. (a) Burial (b) Date thereof 3/2/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Wacker-Helderk
(b) Address 2331 S. Broadway

19. (a) Feb 29 1940 (b) J. J. [Signature]
(Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 29
year 1940 hour _____ minute 1 a. m.

21. I hereby certify that I attended the deceased from Jan 15/40
_____, 19____ to Feb 20/40 19____;
that I last saw him alive on Feb 20 19____
and that death occurred on the date and hour stated above.

Immediate cause of death
myocardial failure 3 Wks.
Arterio-sclerosis 5 yrs
Due to Toxemia following 3 Wks.
influenzal type 3 Wks.
Due to Bronchitis pneumonia 3 Wks.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) 28
Address 201 N. [Signature] Highway Date signed 2/9/40

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.....

Robert Wheeler

Licensed Embalmer No.....

2128

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 this body is not embalmed, above space should be left blank.