

1945

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1153

MAY 22 1945 317  
Registration District No. \_\_\_\_\_

Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Lemay Rural  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County 000  
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17  
(d) Street No. 2500 University St. (If rural, give location) 9  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Laban Wilson,  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 499-03-9409

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 12  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or face White 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Martha Wilson 6. (c) Age When husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 10 1881  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
62 - 2  
hr. \_\_\_\_\_ min.

Immediate cause of death Drowning - Accidental - in Mississippi River near Koch Hospital  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

9. Birthplace Sidney W. Va.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Laborer

11. Industry or business Meyer-Pohlman Furn Co.,

12. Name Jackson Wilson

13. Birthplace West Va.  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Thompson

15. Birthplace West Va.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Evangeline Phelps

(b) Address 2500 University St.

17. (a) Burial (b) Date thereof 5-15-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director Louis H. Bopp Inc.

(b) Address Kirkwood, Mo.

19. (a) MAY 18 1943 (b) C. N. McE...  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) 096  
(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 Louis H. Bopp Inc. Date signed \_\_\_\_\_  
Address \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9600

183-3  
26

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

711

JUN 7 1943

JUN 8

**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..... *Coris H Bapp*

Licensed Embalmer No.....

P. O. Address..... *921*

**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, fact should be so stated above.**