

318 STANDARD CERTIFICATE OF DEATH

ED NOV 10 1943

1003

State File No.

Registrar's No. 9485

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1129 No 9th St
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 17

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1129 No 9th St
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

3. (a) PRINT FULL NAME Willie Wilson

3. (b) If veteran, name was.....

3. (c) Social Security No.....

4. Sex MALE 5. Color or race Black

6. (a) Single, widowed, married, divorced 9

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Oct 18 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months..... Days..... If less than one day..... hr..... min.

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

10. Usual occupation Laborer

11. Industry or business.....

MOTHER FATHER

12. Name Wilson

13. Birthplace Wilson 9
(City, town, or county) (State or foreign country)

14. Maiden name Wilson

15. Birthplace Wilson 9
(City, town, or county) (State or foreign country)

16. (a) Informant James J. Johnson

(b) Address 1300 Clark

17. (a) Date of death 10-18-43
(Month) (Day) (Year)

(b) Place: burial or cremation Washington

18. (a) Signature of funeral director W. J. Bueck

(b) Address 3500 Ridge

19. (a) OCT 28 1943 (b) J. F. Bueck
(Date received local certificate) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1943 hour 8 minute 25 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 Coronary Occlusion
Arteriosclerosis

Due to.....

Due to.....

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

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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 Alfred J. Perry (M.D. or other)
Address Deputy Coroner Date signed 10/18/43

9485

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Nov. 9485*

Registrar's No. *9485*

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town *St. Louis*
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME *Willie Wilson*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *unk*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *Aut. 1923*
(Month) (Day) (Year)

8. AGE: Years *80* Months _____ Days _____ (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *NOV 15 1943* (b) *J. F. Breberk*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

FILED

33605