DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1944 18

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1157

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 196

1. PLACE OF DEATH:

(a) County ____

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

(c) Name of hospital or institution: 4369 Gibson Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ____

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

(d) Street No. 4369 Gibson
(If rural, give location)

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

3. (a) PRINT FULL NAME Cora E. Wilson

3. (b) If veteran, name war ____

3. (c) Social Security No. Nil

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife James Wilson

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

7. Birth date of deceased Oct 3 - 1863 (Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 2 If less than one day ____ hr. ____ min.

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

10. Usual occupation Nil

11. Industry or business ____

FATHER
12. Name James P. Wilson
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jennie Thompson
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Frank Wilson
(b) Address 4369 Gibson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-44 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) JAN 8 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5 year 1944 hour 7:00 P.M. minute ____ M.

21. I hereby certify that I attended the deceased from Jan 2 1944 to Jan 5 1944 that I last saw him alive on Jan 5 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cholecystitis (Acute, Chronic)	2 wks
Broncho distinphysema	1 wk
Due to: Cholecystitis - Family / non-calculous	
Due to: Hypertension	
Other conditions (Include pregnancy within 3 months of death): N	
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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Whitlow Hall (M. D. or other)
Address 1221 Frank Avenue Date signed 1/8/44

(Licensed Embalmer's Statement on Reverse Side)

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.....1284

P. O. Address.....St Louis 9

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.