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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 2 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13509

Registration District No. 818 Primary Registration District No. [illegible] Registrar's No. 3666

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: Enroute Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 28 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St Louis 1921
(If outside city or town limits, write "RURAL")

(d) Street No. 1243a N. Garrison
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country O

3. (a) PRINT FULL NAME Hughie L Wilson

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Col

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

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

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased July (Month) 4th (Day) 1901 (Year)

8. AGE: Years 42 Months 9 Days 15 If less than one day hr. min.

9. Birthplace Lambert (City, town, or county) Miss 1 (State or foreign country)

10. Usual occupation Cook

11. Industry or business P. R. R. Co.

FATHER
12. Name Albert Wilson
13. Birthplace ? (City, town, or county) Miss 1 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace ? (City, town, or county) Miss 1 (State or foreign country)

16. (a) Informant Cornelia Wilson
(b) Address 1243a N. Garrison

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-25-44 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson ~~Greenwood Cem. Rem~~

18. (a) Signature of funeral director Ellis Funeral Home
(b) Address 2820 Stoddard St

19. (a) APR 20 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th year 1944 hour 2 minute 40 P.M.

21. I hereby certify that I attended the deceased from Oct 25, 1943 to Apr. 19, 1944 that I last saw him alive on 4-17- 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency

Due to

Due to

Other conditions
(Include pregnancy within 3 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? — (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address [illegible] Date signed 4/20/44

(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 Myself

....., Registered Apprentice No.....

working under my personal supervision.

Signed Lonnie Boykin

Licensed Embalmer No. 12946

P. O. Address St Louis Mo

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

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