S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6993

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 16

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One week (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town St. Charles (If outside city or town limits, write "RURAL")
(d) Street No. 414 Morgan St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Wilson
3. (b) If veteran, name war No
3. (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 Angeline (Beaver) Wilson
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased March (Month) 17 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
69	10	0	hr. min.

9. Birthplace New York, N. Y. (City, town, or county) (State or foreign country)
10. Usual occupation Day Laborer
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Elsie Lynch
(b) Address Normandy, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18-1945 (Month) (Day) (Year)
(c) Place: burial or cremation St. Charles Memorial Park
18. (a) Signature of funeral director H. C. Dallmeyer Sons Co
(b) Address 801 N. Second St. Charles, Mo
19. (a) 1-34-45 (Date received local registrar) (b) Ernest G. Paul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1945 hour minute M.
21. I hereby certify that I attended the deceased from 1/14 1945 to 1/18 1945 and that I last saw him alive on 1/17 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage (Rt hemiplegia)	48 h
Due to Generalized arteriosclerosis	?
Due to	
Other conditions No (Include pregnancy within 3 months of death)	

Major findings:
Of operations No
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 R O Hayden (M. D. or other) MD
Address Jonesburg, Mo Date signed 1-16-45

1340 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-9-45

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 John E. Dellmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles 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, fact should be so stated above.