DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 28 1945

State File No. 39951

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10946

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:
Mo. Baptist Hospital. 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 17 5

(c) City or town St. Louis. 9
(If outside city or town limits, write "RURAL")

(d) Street No. 5657 Enright Ave. 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Charles A. Wilson.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. 0

5. Color or race W.

6. (a) Single, widowed, married, divorced Married 1

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

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

7. Birth date of deceased Nov. (Month) 9th. (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
76	1	5	hr. min.

9. Birthplace St. Louis. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Grain Broker

11. Industry or business

FATHER
12. Name Robert Wilson.
13. Birthplace New York. (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Alice Casey.
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Alice Wilson.
(b) Address 5657 Enright Ave.

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 12-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Arthur J Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) DEC 16 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 14th.
year 1945 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from 9-1-45, 19, to 12/14-45, 19;
that I last saw h— alive on 12-14-45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Sclerosis General

Due to Myocarditis Chr

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

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 R K Andrews (M. D. or other) 12/15

Address 4932 Morgan Lane Date signed 45

(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 W. H. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.