

U.S. No. 2
OM-5-43
v. 5-17-39
I X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29224**
Registrar's No. **7047**

Registration District No. **318** Primary Registration District No. **1003**

20
17
9
28082
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri.**
(b) City or town **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Weeks**
(Specify whether years, months or days) **2 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **99**
(c) City or town **Marion, Ill.**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route #5**
(If rural, give location) **N.R. 0**
(e) Citizen of foreign country? **no** (Yes or No) **2**
If yes, name country _____

3. (a) PRINT FULL NAME **ALBERT WILSON**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **40**
4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Stella Wilson** 6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **May 22 1886**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **11th** year **1946** hour **2:55** minute **P** M.
21. I hereby certify that I attended the deceased from **7/29/46**, 19, to **Aug. 11th**, 19 **46**, that I last saw him **in** alive on **Aug. 11th**, 19 **46**, and that death occurred on the date and hour stated above.

8. AGE: Years **60** Months **2** Days **19** If less than one day hr. _____ min. _____
9. Birthplace **Evansville Indiana**
(City, town, or county) (State or foreign country)
10. Usual occupation **Hospital Employee**
11. Industry or business **Isolation Hospital**
12. Name **George Wilson**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country) **9**
14. Maiden name **Lulu Brown**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
16. (a) Informant **Stella Wilson**
(b) Address **1803 N. Prairie Ave.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug. 14 - 46**
(Month) (Day) (Year)
(c) Place: burial or cremation **Valhalla Cemetery**
18. (a) Signature of funeral director **A. W. McLaughlin**
(b) Address **2301 Lafayette**
19. (a) **AUG 13 1946** (Date received local registrar) **J. F. Bredebeck** (Registrar's signature)

Immediate cause of death **Cerebral hemorrhage**
Due to **Thrombocytopenic purpura**
Due to _____
Other conditions (Include pregnancy within 3 months of death) **82**
Major findings: Of operations _____
Of autopsy _____
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 **Bennett of Carter M.C. 0**
23. Signature **1515 Lafayette** **8/12/46** (Date signed) _____
Address _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 O. W. Cooper

Licensed Embalmer No. 5830

P. O. Address 2301 Lafayette

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.