

FILED NOV 25 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

392433

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **DC75**

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:
1305^a Linden St 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **20 yrs**
years, months or days

3. (a) PRINT FULL NAME **RSZALEE WILSON**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 3 5. Color or race **cd** 6. (a) Single, widowed, married, divorced **widow**

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

7. Birth date of deceased **Feb 28 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 8 12
hr. min.

9. Birthplace **Camden TENN**
(City, town, or county) (State or foreign country)

10. Usual occupation **nil**

11. Industry or business _____

MOTHER FATHER
12. Name **Moses Wallace**
13. Birthplace **Camden Tenn**
(City, town, or county) (State or foreign country)
14. Maiden name **Jennie Flowers**
15. Birthplace **Camden Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hella Thompson**

(b) Address **325 - 29th St Cairo Ill**

17. (a) **Burial** (b) Date thereof **11-14-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **J. F. Bradley**

(b) Address **3133 Bell Ave**

19. (a) **NOV 13 1946** (Date received local registrar) **J. F. Bradley** (Registrar's signature)

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. **1305^a Linden St**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **10th**
year **1946** hour **8** minute **07 A. M.**

21. I hereby certify that I attended the deceased from **May 27**, 1946, to **Nov 8**, 1946, that I last saw her alive on **Nov 8**, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: **Septicemia** Duration **1 week**

Due to: **Infected leg ulcer**

Due to: _____

Other conditions (Include pregnancy within 3 months of death) **15^{yr}**

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **LaCadene A Hill** (M. D. or other) Address **823 N 16th St** Date signed **11-12-46**

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

ml

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 *J. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2749 Charlotte*

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.