

No. 2  
-12-45  
-17-39  
X47070

FILED MAR 24 1947

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

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. 4135 Olive Street.  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Wilson

3. (b) If veteran, name war None 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Sallie Wilson 6. (c) Age of husband or wife if alive Unk years

7. Birth date of deceased August 12 1894  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9  
year 1947 hour 4 minute 38 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>6</u>	<u>17</u>	_____ hr. _____ min.

Immediate cause of death \_\_\_\_\_  
Bilateral Lobar Pneumonia  
Chronic Myocarditis

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace New York City New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Tavern

MOTHER FATHER { 12. Name Frank Wilson

13. Birthplace Unknown New York  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca O'Connor

15. Birthplace Unknown New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Sallie Schmidt  
(b) Address 3204 North Taylor Avenue

17. (a) Burial (b) Date thereof 3/10/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.

19. (a) MAR 10 1947 (b) J. J. Brodeck  
(Date received local registrar) (Registrar's signature)

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) (c) Means of injury \_\_\_\_\_

23. Signature Patience E. May M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 3/10/47

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

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**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. W. Wilkinson*  
Licensed Embalmer No..... *3575*

P. O. Address.....

**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.**