

No. 2
1/47
17-39

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29684
8225
Registrar's No.

Registration District No. 378
FILED SEP 8 1947

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution Primary Hospital
(d) Length of stay: In hospital or institution 12/19/45 to 8/12/47
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County Gas
(c) City or town St. Louis
(d) Street No. 5800 Arsenal St.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME JAMES WILSON
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male / 5. Color or race white
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar. 22 1862

8. AGE: Years 85 Months 4 Days 20
If less than one day hr. min.

9. Birthplace Pittsburgh Pennsylvania

10. Usual occupation Nil

11. Industry or business

12. Name James Wilson

13. Birthplace Penna.

14. Maiden name Mary ?

15. Birthplace Penna.

16. (a) Informant City Infirmery Records
(b) Address 5800 Arsenal St.

17. (a) Anatomical Body Date the of 8-20-47
(b) Place: burial or cremation Washington

18. (a) Signature of funeral director J. F. Prebeck
(b) Address 3500 Rutledge
19. (a) Date received 8-29-47 (b) Registrar's signature

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug. day 12
year 1947 hour 4 minute 10
21. I hereby certify that I attended the deceased from July 1, 1947, to Aug. 12, 1947
that I last saw him alive on Aug. 12, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia
Carcinoma of gall bladder
Due to Metastatic to liver and regional lymph nodes
Other conditions Secondary anemia
Major findings: Of organ Arteriosclerotic Heart Disease
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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
23. Signatur Warren C. Lewis M.D.
Address 5600 Arsenal Date signed 8-13-47

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

MOTHER FATHER

PHYSICIAN

Underline the cause of 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.....

Licensed Embalmer No.....

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.