

No. 2
-1/47
5-17-39

National Office of Vital Statistics
FILED FEB 24 1948

Registration District No. **567**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **rural**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Robert Koch Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **258 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **o.c.**

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

(d) Street No. **2901 Franklin**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **James Henry Wilson**

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **2**
year **1948** hour **7** minute **50** pm

4. Sex **male** 2

5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **Ethel Mitchell Wilson**

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

7. Birth date of deceased: **Oct 25 1911**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **5-20-47**, 19....., to **2-2-48**, 19....., that I last saw him alive on **2-2-48**, 19....., and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Duration **13 Mos.???**

8. AGE:	Years	Months	Days	If less than one day
	36	3	7hr.min.

Due to **13 b**

Due to

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **Parkin Ark.**
(City, town, or county) (State or foreign country)

10. Usual occupation **stock clerk**

PHYSICIAN

Major findings: Of operations

Of autopsies

Underline the cause of which death should be charged statistically.

11. Industry or business

12. Name **Henry Wilson**

13. Birthplace **Brownville, Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Mabel McCloud**

15. Birthplace **Wynne, Ark.**
(City, town, or county) (State or foreign country)

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)

16. (a) Informant **Robert Koch Hospital records**

(b) Address **Robert Koch Hospital, Koch, Mo.**

17. (a) **PARKIN, ARK** (b) Date thereof **2-7-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **PARKIN, ARK**

18. (a) Signature of funeral director **Chas. D. Patten**

(b) Address **303 S. 4th St. St. Louis**

19. (a) **2-6-48** (b) **Henry C. Shaffer**
(Date received local registrar) (Registrar's signature)

While at work? (e) Means of injury

23. Signature **Williams C. Barton II** (M. D. or other)

Address **Robert Koch Hospital** Date signed **2-3-48**

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

MOTHER FATHER

FEB 25 1948

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. Claude Gordon*

Licensed Embalmer No. *3483*

P. O. Address. *457 1/2 Aldine*

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.