

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

11154

State File No. _____

FILED APR 5 1948

6676

727

Registration District No. 379

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Jefferson Barracks, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 Days
(Specify whether
In this community 22 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County Finney
(c) City or town Garden City
(If outside city or town limits, write "RURAL")
(d) Street No. 714 Jones Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILSON, Ottis C.

3. (b) If veteran, name war VW-1 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jennie H. Wilson 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased August 27 1890
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>6</u>	<u>22</u>	_____ hr. _____ min.

9. Birthplace Chariton, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business _____

12. Name Mr. William Wilson

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Mary Williams

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Registrar

(b) Address VA Hosp. Jefferson Barracks, Mo.

17. (a) Removal (b) Date thereof 3-19-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Garden City, Kansas

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) 3-19-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1948 hour 8:02 minute A. M.

21. I hereby certify that I attended the deceased from February 26, 1948, to March 19, 1948;
that I last saw him alive on March 19, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC NEPHRITIS

~~Other~~ Contributory cause:
1. ANEMIA 2. AZOTEMIA 3. BRONCHO-
PNEUMONIA, PULMONARY HEMORRHAGE

Other conditions (Include pregnancy within 3 months of death) 1314

Major findings: Of operations _____

Of autopsy Autopsy performed
(See cause of death)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(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? L. E. Stilwell (Specify type of place) (Means of injury)

23. Signature L. E. Stilwell (M. D. or other)

Address VAH, Jefferson Barracks, Mo Date signed 3/19/48

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

MOTHER FATHER

APR 22 1948

APR 6 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.....

Henry M. Brammer

Licensed Embalmer No.....

P. O. Address.....

*1200
St. Louis*

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.