

No. 300  
M-10-47  
v. 5-17-39  
I 3906

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31543**

FILED OCT 9 1948 **318**

**1003**

Registrar's No. **8533**

Registration District No. ....

Primary Registration District No. ....

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

**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:  
Homer G Phillips Hospital **0**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 2 days  
(Specify whether Life)

In this community..... Life  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... Mo (b) County..... 17

(c) City or town..... St Louis  
(If outside city or town limits, write "RURAL") 7

(d) Street No..... 2325 Carr  
21 (If rural, give location)

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

**3. (a) PRINT FULL NAME** Benny Jean Wilson

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex Male **3** 5. Color or race Negro

6. (a) Single, widowed, married, divorced Single **0**

6. (b) Name of husband or wife.....

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

7. Birth date of deceased..... July 14 1948  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day

5 - 12 7 12 hr. min.

9. Birthplace..... St Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation..... Nil

11. Industry or business..... Nil

**MOTHER FATHER** 12. Name..... Joe Wilson

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

14. Maiden name..... Mattie Murray  
(City, town, or county) (State or foreign country)

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

16. (a) Informant..... Homer G Phillips Hospital

(b) Address..... 2601 N Whittier St

17. (a) Anatomical Board Date thereof..... SEP 30 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Anatomical Board

18. (a) Signature of funeral director..... Rowland Mortuary Service

(b) Address..... 4104 Manchester Ave.

19. (a) SEP 30 1948 (b) J. F. Breda  
(Date of death) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH, Month August day 26  
year 1948 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from  
August 24, 1948, to August 26, 1948,  
that I last saw him alive on August 26, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Severe Diarrhea

Duration..... Unk

Due to..... 1192

Due to.....

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

Major findings:  
Of operations.....

Of autopsy.....

**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..... D. Daniels (M. D. State)  
Address..... 2601 N Whittier St Date signed..... 8-27-48

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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.....

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.**