No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

#52633

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 9 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 31547

Registrar's No. 8508

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-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

In this community 20years

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. 615 Walnut St.,
Memorial
(If rural, give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME TOM 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 March (Month) 15th (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
abt 82	~		hr. min.

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

10. Usual occupation Odd Jobs

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof SEP 30 1948 (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 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14th year 1948 hour 2 minute A M.

21. I hereby certify that I attended the deceased from 9/10/48, 19..., to Sept. 14th, 19 48 that I last saw him alive on Sept. 14th, 19 48 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Complete Heart Block

Duration

Due to

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Bruenle M.D. (Attending physician)
Address 2515 Lafayette Date signed 9/14/48

(Licensed Embalmer's Statement on Reverse Side)

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.