

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 43086

318

1003

Registrar's No. 16568

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 16568	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived; if Institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2724 Dayton</u>				d. STREET ADDRESS (If rural, give location) <u>2724 Dayton</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>			b. (Middle) _____		c. (Last) <u>Wilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 6 1949</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>ed</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Sep 11, 1896</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Ark.</u>		12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>George Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>George Wilson 2724 Dayton</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Arterio-sclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>unknown</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>97</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>B31X</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 27</u> , 19 <u>49</u> , to <u>Nov. 6</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>December 5</u> , 19 <u>49</u> , and that death occurred at <u>1:35 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>L. J. Brock, M.D.</u> (Degree or title) _____				23b. ADDRESS <u>St. Louis Mo</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24b. DATE <u>Dec 10, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>		
DATE REC'D BY LOCAL REG. <u>DEC 8</u>		REGISTRAR'S SIGNATURE <u>L. J. Brock</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. G. Green 4214 Delmar</u>			

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed F. A. Green.....

Licensed Embalmer No. 2963.....

P. O. Address 4217 Delmar.....

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.