

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22150

4693

BIRTH NO. _____		REG. DIST. NO. 600	PRIMARY REG. DIST. NO. 818	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2049		
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		STREET ADDRESS (If rural, give location) 6426 W. 11th		
3. NAME OF DECEASED (Type or Print) a. (First) John		b. (Middle) Wilson		c. (Last) Wilson
4. DATE OF DEATH (Month) (Day) (Year) 5/28/50				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 5/15/1884	9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME Wm. Wilson		13b. MOTHER'S MAIDEN NAME Catherine Whang		14. NAME OF HUSBAND OR WIFE Elizabeth Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Elizabeth Wilson
17. ADDRESS _____				
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, asthenia, etc.: It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Bronchitis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
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) _____
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? 163X
22. I hereby certify that I attended the deceased from July 1, 1948 , to July 29, 1950 , that I last saw the deceased alive on May 27, 1950 and that death occurred at 4:30 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE W. E. Sheets M.D.		23b. ADDRESS 961 S. Sprink		23c. DATE SIGNED May 28 1950
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5		24c. NAME OF CEMETERY OR CREMATORY St. Patricks
24d. LOCATION (City, town, or county) (State) Alton Ill				
DATE REC'D BY LOCAL REG. MAY 28 1950		REGISTRAR'S SIGNATURE J. B. Lucater		25. FUNERAL DIRECTOR'S SIGNATURE Robert H. Steepert
				ADDRESS _____

(Licensed Embalmer's Statement on Reverse Side) **2321 Edwards Alton Ill**

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.....

Robert H. Steep

Licensed Embalmer No.

2474

P. O. Address.....

2521 Edwards Ave

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.