

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22152**
Registrar's No. **5008**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis Mo	c. LENGTH OF STAY (in this place) 33 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Centralia 8129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 555 N. Hickory	

3. NAME OF DECEASED (Type or Print) CLARA	a. (First) M	b. (Middle) WILSON	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 6-6-50
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-25-1883	9. AGE (In years last birthday) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Angora, Iowa	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Christian Johnson	13b. MOTHER'S MAIDEN NAME Caren Larson	14. NAME OF HUSBAND OR WIFE Theo. E. Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Theo. E. Wilson-Centralia, Ill.

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE MYOCARDIAL INFARCTION ARTERIO-SCLEROTIC HEART DISEASE E ARRIBULAR FIBRILLATION		
	ANTECEDENT CAUSES Morbid 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 5-15-50	19b. MAJOR FINDINGS OF OPERATION MARLED SCARRING OF PYLORUS	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 345X

22. I hereby certify that I attended the deceased from **5-4**, 19**50**, to **6-6**, 19**50**, that I last saw the deceased alive on **6-6**, 19**50**, and that death occurred at **12:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE FR Bradley	(Degree or title) MD	23b. ADDRESS Barnes Hosp	23c. DATE SIGNED 6/6/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6/7/50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Centralia, Ill.

DATE REC'D BY LOCAL REG. JUN 7 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Queen-Boggs, Inc. Centralia, Ill.
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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

.....
working under my personal supervision.

Student Embalmer No.

Signed

Signed.....

Student Embalmer

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.