

FILED AUG 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28805
6907 Registrar's No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri		b. COUNTY New Madrid		
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) Parma 0920		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1127 N. Park Pl.		d. STREET ADDRESS (If rural, give location) /				
3. NAME OF DECEASED (Type or Print) Alma			a. (First)		b. (Middle) Wilson	
c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) August 12, 1950			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow		
8. DATE OF BIRTH March 17, 1864		9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months Days		
11. IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Josephus Wilson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ethel Webster, 1127 N. Park Pl.		
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)		MEDICAL CERTIFICATION Gangrene both legs		INTERVAL BETWEEN ONSET AND DEATH 3 days		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		Thrombosis abdominal aorta 3 days		
DUE TO (c)		General arteriosclerosis		5 years		
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? 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? 4501		
22. I hereby certify that I attended the deceased from April 1950, to Aug 12, 1950, that I last saw the deceased alive on Aug 12, 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.						
23a. SIGNATURE Martin W. Davis, M.D.		(Degree or title)		23b. ADDRESS 539 N. Grand		
23c. DATE SIGNED 8/13/50						
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-13-50		24c. NAME OF CEMETERY OR CREMATORY		
24d. LOCATION (City, town, or county) (State) Malden, Mo.						
DATE REC'D BY LOCAL REG. AUG 14 1950		REGISTRAR'S SIGNATURE J. B. Fosater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.		
ADDRESS						

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.....
Student Embalmer

Signed

J. Wm Binkley

Licensed Embalmer No. *3653*

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.