

S. No. 300
v. 10.48

FILED 10 10 1950
Reg. # 789021

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35827

State File No. _____

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 2425	
1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON BARRACKS, MO.		c. LENGTH OF STAY (In this place) 1 HOUR		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		State 2179	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.				e. STREET ADDRESS (If rural, give location) 3414 HENRIETTA			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) M.		c. (Last) WILSON		4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 9, 1950	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-25-92		9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 15 Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME CLARENCE WILSON		13b. MOTHER'S MAIDEN NAME MARY WALLACE		14. NAME OF HUSBAND OR WIFE STELLA WILSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) YES WW-I		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS			
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) INTESTINAL HEMORRHAGE DUE TO ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUODENAL ULCER DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CHRONIC ENDOCARDITIS OF AORTIC VALVE WITH STENOSIS					INTERVAL BETWEEN ONSET AND DEATH 3 days 5 4/20
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE		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) (Min.) VA		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-9-50 , to 10-9-50 , and that death occurred at 5:05P m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Maxim D. Orshook, M.D.				23b. ADDRESS VET ADM HOSP, JEFF BRKS, MO.		23c. DATE SIGNED 10-9-50	
24a. FUNERAL (CREMATION REMOVAL) (Specify)		24b. DATE Oct 12 50		24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY, JB, MO.		24d. LOCATION (City, town, or county) (State) JEFFERSON BRKS, MISSOURI	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 10 1950		REGISTRAR'S SIGNATURE Herbert R. Donke M.D.		FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS J. J. SCHNUR FUNERAL HOME 3125 LAFAYETTE, ST. LOUIS, MISSOURI			

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 *Just B. Hollmer*

Licensed Embalmer No. *2014*

P. O. Address *312 Dupont*

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.