

FILED JAN 26 1951

STANDARD CERTIFICATE OF DEATH

State File No. **3154**
272

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		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 St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 2 mos.		d. STREET ADDRESS (If rural, give location) 4306 Eichlermergen St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Carl b. (Middle) W. c. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) Jan. 8, 1951	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 20, 1908
9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker	11. BIRTHPLACE (State or foreign country) South East Kentucky
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Samuel B. Wilson	13b. MOTHER'S MAIDEN NAME Emma Elizabeth Dobson	14. NAME OF HUSBAND OR WIFE Minnie W. Wilson
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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. 498-10-6908	17. INFORMANT'S SIGNATURE OR NAME Minnie W. Wilson	ADDRESS 4306 Eichlermergen
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis.		
	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. chronic cholecystitis		1 year	

19a. DATE OF OPERATION 1-6-51	19b. MAJOR FINDINGS OF OPERATION chronic cholecystitis	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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? 585X

22. I hereby certify that I attended the deceased from **Sept. 1950**, to **Jan 8, 1951**, that I last saw the deceased alive on **Jan 8, 1951**, and that death occurred at **12:30 am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert W. Tichenor M.D.	23b. ADDRESS 4602 Travis St. Louis 16 Mo	23c. DATE SIGNED 1-9-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 11, 1951	24c. NAME OF CEMETERY OR CREMATORY New Pictur Cem.	24d. LOCATION (City, town, or county) (State) 7133 Keravia Ave. St. Louis Mo
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DATE RECD. BY LOCAL REG. JAN 1 1951	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Bull - Campbell Mortuary	ADDRESS 4215 Lindbergh
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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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

Rex E. Campbell

Licensed Embalmer No

3881

P. O. Address

St Louis 8 Mo

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.