

FILED APR 10 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11177

No. 300  
10. 48  
Reg# 92679

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 767

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place) 2 DAYS		d. STREET ADDRESS (If rural, give location) 4359 ALDINE ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP			

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) T. c. (Last) WILSON			4. DATE OF DEATH (Month) (Day) (Year) MARCH 21 1951			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED, MARRIED	8. DATE OF BIRTH 11-14-93	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MERIDIAN, MISSISSIPPI /		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME HOUSTON WILSON	13b. MOTHER'S MAIDEN NAME ELIZABETH PURELL	14. NAME OF HUSBAND OR WIFE MILDRED WILSON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. 494 01 5862	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS	ADDRESS JEFF BRKS, MO.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) papillary muscle of heart - RUPTURE OF LEFT PAPILLARY MUSCLE OF HEART - MYOCARDIAL FAILURE		
	ANTECEDENT CAUSES DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE		
	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 of MO.	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) VA m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-20 19 51, to 3-21 19 51, and that death occurred at 10:00p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Clarence T. Wilson</i>	(Degree or title) M.D.	23b. ADDRESS VAH JEFFERSON BARRACKS, MO.	23c. DATE SIGNED 3-22-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3-28-51	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 3/24/51	REGISTRAR'S SIGNATURE <i>Herbert P. Tomke</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>SNEED FUNERAL CHAPEL</i>	ADDRESS ST. LOUIS, MO.
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(Licensed Embalmer's Statement on Reverse Side)

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 *Leroy W. Gannister*

Licensed Embalmer No. *4523*

P. O. Address *3880 Easton 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.