S. No. 300
. 10.48

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

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39932

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10881

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 7 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2219
d. STREET ADDRESS (If rural, give location): 1423 N Jefferson

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle):
c. (Last): Wilson

4. DATE OF DEATH (Month) (Day) (Year): Dec. 5 1951

5. SEX: Female 3

6. COLOR OR RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widow 2

8. DATE OF BIRTH: Nov. 25, 1886

9. AGE (In years last birthday): 65
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): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: U S A

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: widow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: James Wilson, son, 1423 N Jefferson

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Undetermined
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 171X

22. *I hereby certify that I attended the deceased from* 11-8, *19* 51, *to* 12-5, *19* 51, *that I last saw the deceased alive on* 12-5, *19*51, *and that death occurred at* 12:10pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clarence M Turner M. D.

23b. ADDRESS: 2601 N Whittier St

23c. DATE SIGNED: 12-6-51

24a. BURIAL, CREMATION, REMOVAL (Specify): B

24b. DATE: Dec 10/51

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State): East St Louis Ill.

DATE REC'D BY LOCAL REG.: DEC 8 1951

REGISTRAR'S SIGNATURE: Earl Smith M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. A. Green 4714 Delmar

(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 Eugene Miles

Licensed Embalmer No. 3623

P. O. Address 4214 Delma

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.