No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3473
Registrar's No. 583

FILED FEB 2 1952

BIRTH NO. 9455 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis Children's 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): Big Piney 0850
d. STREET ADDRESS (If rural, give location): 1

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

4. DATE OF DEATH (Month) (Day) (Year): 1-19-52

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: 1-16-52
9. AGE (In years last birthday): 3 days
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):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Haynesville, Missouri
12. CITIZEN OF WHAT COUNTRY?: America

13a. FATHER'S NAME: Ernest D. Wilson
13b. MOTHER'S MAIDEN NAME: Ellie Olson
14. NAME OF HUSBAND OR WIFE:

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.:
17. INFORMANT'S SIGNATURE OR NAME: J. Young
ADDRESS: 505 So. Kingshighway St. Louis

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): Multiple Congenital
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): anomalies
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

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?: 7593

22. *I hereby certify that I attended the deceased from* 1-16-a.m., 1952, *to* 1-19, 1952, *that I last saw the deceased alive on* 1-19, 1952, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Earl Smith M.D.
(Degree or title): M.D.
23b. ADDRESS: Barnes Hospital 505 Kingshighway
23c. DATE SIGNED: 1/20/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/21/52
24c. NAME OF CEMETERY OR CREMATORY: ~~Lickering Funeral Home~~
24d. LOCATION (City, town, or county) (State): Lickering Mo

DATE REC'D BY LOCAL REG.: JAN 21 1952
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
FUNERAL DIRECTOR'S SIGNATURE: Lickering Funeral Home
ADDRESS: Lickering Mo

(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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.