

FILED NOV 13 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37014**
Registrar's No. **9724**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 5021 Waterman Avenue.,	

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle) Oscar	c. (Last) Wilson	4. DATE OF DEATH (Month) (Day) (Year) 10 21 52
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH June 6 1884	9. AGE (In years last birthday) Months Days Hours Mins. 68
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman	10b. KIND OF BUSINESS OR INDUSTRY Wrought Iron Range	11. BIRTHPLACE (City and State or Foreign Country) <input checked="" type="checkbox"/> Bismarck, Missouri	12. CITIZENRY OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Wilson	13b. MOTHER'S MAIDEN NAME Margaret White	14. NAME OF HUSBAND OR WIFE Esther
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME Maxine DuFour	ADDRESS 5807a Thekla Ave.,
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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, asphyxia, 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) Metastatic carcinoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary site? 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	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 1999
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22. I hereby certify that I attended the deceased from **10/14/52** to **10/21**, 19**52** that I last saw the deceased alive on **10/21/52**, and that death occurred at **8:00pm.**, from the causes and on the date stated above.

23a. SIGNATURE FR Pringley	(Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10/22/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-22-52	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	24d. LOCATION (City, town, or county) (State) Fredericktown, Missouri
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DATE REC'D BY LOCAL REG. OCT 2 2 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Generalized carcinoma site unknown

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.

Signed _____

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

Student
Student Embalmer

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.