

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44550**

FILED DEC 17 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**Registrar's No. **11749**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11749	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN Madison (Venice)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital				e. STREET ADDRESS (If rural, give location) 1114 Logan Street			
3. NAME OF DECEASED (Type or Print) a. (First) Guy b. (Middle) _____ c. (Last) Wilson			4. DATE OF DEATH (Month) (Day) (Year) December 10 1953				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 10, 1881	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (City and State or Foreign Country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Wilson		13b. MOTHER'S MAIDEN NAME Sarah Isaacson		14. NAME OF HUSBAND OR WIFE Dora Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dora Wilson 1114 Logan Street			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction, acute ANTECEDENT CAUSES Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH 5 days 25 yrs	
19a. DATE OF OPERATION 12-3-53		19b. MAJOR FINDINGS OF OPERATION _____				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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from 12-2- , 1953, to 12-10 , 1953, that I last saw the deceased alive on 12-10- , 1953, and that death occurred at 9:30 p. m. , from the causes and on the date stated above.							
23a. SIGNATURE FR Bradley			23b. ADDRESS M.D. 9 BARNES HOSPITAL			23c. DATE SIGNED 12-11-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/13/1953		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Hebrew		24d. LOCATION (City, town, or county) (State) University City, Missouri	
DATE REC'D BY LOCAL REG. DEC 14 1953		REGISTRAR'S SIGNATURE J. C. Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson Ave.			

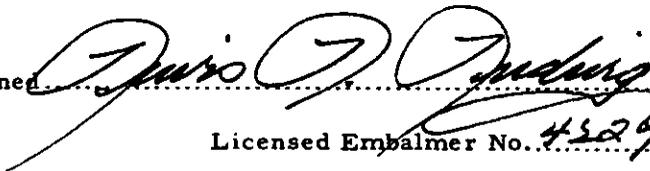
(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4529

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.