

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3438

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0570

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 town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2069	
c. LENGTH OF STAY (in this place) 37 yrs.		d. STREET ADDRESS (If rural, give location) 3015 Abner Place 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3015 Abner Place			
3. NAME OF DECEASED (Type or Print) a. (First) MAUD		b. (Middle) R. c. (Last) WILSON	
4. DATE OF DEATH (Month) (Day) (Year) Jan. 16, 1954.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 10, 1872.
9. AGE (in years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MINS. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Des Moines, Iowa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Draper		13b. MOTHER'S MAIDEN NAME Elizabeth Dixon	
14. NAME OF HUSBAND OR WIFE Sherman E. Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Sherman E. Wilson		ADDRESS 3015 Abner Place	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coracai facies		1 week	
DUE TO (c) Hypertension		year	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cercho-vascular thrombosis		3 mo	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? 443X			
22. I hereby certify that I attended the deceased from 1953, to 1-16, 1954, that I last saw the deceased alive on 1-16, 1954, and that death occurred at 9:40 P. m., from the causes and on the date stated above.			
23a. SIGNATURE M. Kimmelma. M.D.		23b. ADDRESS 3409 Union St. Louis, Mo.	
23c. DATE SIGNED 1-18-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/20/54	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
DATE REC'D BY LOCAL REG. JAN 19 1954		REGISTRAR'S SIGNATURE J. Calvin F. Feutz	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 4828 Natural Bridge Blvd.	

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

Go 4629 Office  
De 6707 Res

NOV 13 1958

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 Ralph C. Linders

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

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.