

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34401

State File No.

No. 300
10. 48

2500
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BIRTH NO. _____ REG. DIST. NO. 4249 PRIMARY REG. DIST. NO. 159 Registrar's No. 41

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Hillsboro</u>	c. LENGTH OF STAY (in this place) <u>4 days</u>	c. CITY OR TOWN <u>Affton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedar Grove Home</u>		STREET ADDRESS (If rural, give location) <u>5101 Lakewood Ave. # 207</u>	
3. NAME OF DECEASED a. (First) <u>John</u> b. (Middle) <u>H.</u> c. (Last) <u>Wilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 29 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 6 1875</u>
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Laclede Gas Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Bakersville, N. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>-- Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Mary E. Wilson (Deceased)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Dallas Wilson Ironton, Mo.</u>
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis with left hemiplegia & dip.</u> INTERVAL BETWEEN ONSET AND DEATH <u>?</u> ANTECEDENT CAUSES DUE TO (b) <u>Cerebral arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u></u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia, 48 hours</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
19a. DATE OF OPERATION <u></u>	19b. MAJOR FINDINGS OF OPERATION <u>332 X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u></u>	
22. I hereby certify that I attended the deceased from <u>Sept 27, 1954</u> , to <u>Sept 29, 1954</u> that I last saw the deceased alive on <u>Sept 29, 1954</u> and that death occurred at <u>5:30 p. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Thomas A. Donnell - M.D.</u>		23b. ADDRESS <u>Desoto, Mo.</u>	23c. DATE SIGNED <u>9-30-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Oct 2, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
DATE REC'D BY LOCAL REG. <u>10-1-54</u>	REGISTRAR'S SIGNATURE <u>Kathleen Menden</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John L. Ziegenhein & Sons 7027 Gravois St. Louis 16 Mo.</u>	

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

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI

DATE RECEIVED

OCT 11 1954

OCT 11 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Donald C. Benz*

Licensed Embalmer No. *48*

P. O. Address *7027*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.