

36136

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 26 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8799**

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY _____

b. CITY OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN St. Louis d. In Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary e. STREET ADDRESS (If rural, give location) 3313 Caroline 2187

3. NAME OF DECEASED (Type or Print) a. (First) Colleen b. (Middle) Yvonne c. (Last) Wilson 4. DATE OF DEATH (Month) (Day) (Year) 9-26-54

5. SEX F 6. COLOR OR RACE negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____ 8. DATE OF BIRTH July 13, 1951 9. AGE (In years last birthday) 3 If UNDER 1 YEAR Months 2 If UNDER 12 HRS. Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Gracie Wilson 13b. MOTHER'S MAIDEN NAME Camilla Eberhart 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Gracie Wilson ADDRESS 3313 Caroline

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Congestion
DUE TO (c) Cerebral Palsy
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 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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 334x

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 600A m., from the causes and on the date stated above.

22a. SIGNATURE Carl Smith (Degree or title) _____ 22b. ADDRESS 1300 Clark St 22c. DATE SIGNED 9-27-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Sept. 28, 1954 24c. NAME OF CEMETERY OR CREMATORY Greenwood 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. SEP 27 1954 REGISTRAR'S SIGNATURE Carl Smith 25. FUNERAL DIRECTOR'S SIGNATURE W. B. Foyce ADDRESS 12217. Blvd

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 *M. L. B. Black*.....

Licensed Embalmer No. *296*.....

P. O. Address *1221 N*.....

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.