

FILED NOV 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36137

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9608**

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

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 OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) 45 yrs.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		e. STREET ADDRESS (If rural, give location) 3121 Thomas Street			
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) c. (Last) WILSON			4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1954		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 3, 1885	9. AGE (in years last birthday) 69 if UNDER 1 YEAR Months 5 Days 10 if UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY U. Methodist Ch.		11. BIRTHPLACE (City and State or Foreign Country) Jacksonville, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Charles Wilson		13b. MOTHER'S MAIDEN NAME Carrie Jordan		14. NAME OF HUSBAND OR WIFE Grace Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Grace Wilson ADDRESS 3121 Thomas 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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES: DUE TO (b) Hypertension 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 2 wks. Unkown
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? 332x	
22. I hereby certify that I attended the deceased from August, 1954 , to Oct 19, 1954 , that I last saw the deceased alive on Oct 17, 1954 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE [Signature] (Degree or title)			23b. ADDRESS 110 Jefferson St. St. Louis		23c. DATE SIGNED 10-22-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/24/54	24c. NAME OF CEMETERY OR CREMATORY Diamond Grove Cemetery		24d. LOCATION (City, town, or county) (State) Jacksonville, Illinois
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Oct 23 1954 [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Charles J. Gates 4107 Finney Ave.			

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.....
R. H. ...

Licensed Embalmer No. 43

P. O. Address 4107 Finne

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.