

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 44141
Registrar's No. 11566

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11566			
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 township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		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: Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 924 N. 19th St.					
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) _____ c. (Last) Wilson			4. DATE OF DEATH (Month) 12 (Day) 16 (Year) 54						
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 7-21-1895			
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 4 Days 26		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Annie 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. 486-20-8048		17. INFORMANT'S SIGNATURE OR NAME Annie Wilson		ADDRESS 924 N. 19th Street			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia; Arteriosclerotic Heart Disease ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Aortic Aneurysm Renal Cyst, Left Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH Undt.		
19a. DATE OF OPERATION _____		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) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 42008					
22. I hereby certify that I attended the deceased from 12-3 , 19 54 , to 12-16 , 19 54 , that I last saw the deceased alive on 12-16 , 19 54 , and that death occurred at 2:15 P.m. , from the causes and on the date stated above.									
23a. SIGNATURE Edw. B. Williams			(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 12-17-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-21-54		24c. NAME OF CEMETERY OR CREMATORY Greenwood		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. DEC 20 1954		REGISTRAR'S SIGNATURE Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, Inc.			ADDRESS 2820 Stoddard St.	

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 *Fulton E. Culkin*.....

Licensed Embalmer No. *419*.....

P. O. Address *St. Louis*.....

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.