

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

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED MAY 25 1955

State File No. **17128**
Registrar's No. **4177**

318 PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 17128		Registrar's No. 4177	
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) 55 yrs.		c. CITY OR TOWN St Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital				e. STREET ADDRESS 5100 Arsenal St.		21390			
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) - c. (Last) Wilson			4. DATE OF DEATH (Month) (Day) (Year) May 3 1955						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5/28/1869		9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS. Days 6		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroading			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Wilson			13b. MOTHER'S MAIDEN NAME Mattie Kittle			14. NAME OF HUSBAND OR WIFE -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure				8 days	
* This does not mean the mode of dying, such as heart failure, asthenia, 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) Arteriosclerotic heart disease				14 years	
				DUE TO (c) _____					
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 <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) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200					
22. I hereby certify that I attended the deceased from 4-7 , 19 47 , to 5-3 , 19 55 that I last saw the deceased alive on 5-3 , 19 55 , and that death occurred at 6:10 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE L. K. Korballee M.D. (Degree or title)				23b. ADDRESS 5400 Arsenal Street				23c. DATE SIGNED 5-5-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-3-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board St Louis, Mo		24d. LOCATION (City, town, or county) (State) _____			
DATE REC'D BY LOCAL REG. MAY 11 1955		REGISTRAR'S SIGNATURE J. Carl Smith				25. FUNERAL DIRECTOR'S SIGNATURE Ms Rowland. Aker. 4107 Manchester. ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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 *John E. Embalmer*.....
Licensed Embalmer No. *10000*

P. O. Address.....

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.