

FILED MAY 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17129**
Registrar's No. **3995**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3995	
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 town(ship) OR TOWN SAINT LOUIS:		c. LENGTH OF STAY (in this place) 10 DAYS		c. CITY OR TOWN SAINT 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 MISSOURI BAPTIST HOSPITAL.				STREET ADDRESS (If rural, give location) 12 4953 McPHERSON AVE. 21290			
3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL		b. (Middle) GRAHAM		c. (Last) WILSON JR.		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) MARRIED		8. DATE OF BIRTH AUGUST 10 1878.	
9. AGE (In years last birthday) 76.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEALER-MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY UPHOLSTER FABRICS		11. BIRTHPLACE (City and State or Foreign Country) MACON, MISSOURI.			
13a. FATHER'S NAME SAMUEL GRAHAM WILSON			13b. MOTHER'S MAIDEN NAME SARAH POUILLAIN			14. NAME OF HUSBAND OR WIFE MARIE PECKHAM WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO.		16. SOCIAL SECURITY NO. 495-36-8913		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARIE P. WILSON - 4953 McPHERSON AVE.			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage, left DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 Year 5 Days	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X			
22. I hereby certify that I attended the deceased from 12-1 , 19 43 , to 5-3 , 19 55 , that I last saw the deceased alive on 5-3 , 19 55 , and that death occurred at 4:050 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. Earl Smith, M.D.				23b. ADDRESS 4500 Olive		23c. DATE SIGNED 5-5-55	
24. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAY 5/55		24c. NAME OF CEMETERY OR CREMATORY BELLEFONTAINE CEMETERY		24d. LOCATION (City, town, or county) (State) SAINT LOUIS, MISSOURI.	
DATE REC'D BY LOCAL HEALTH OFFICER MAY 5 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. LUPTON & SONS - 7233 DELMAR BLVD.			

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 *Clarence A. Mur*.....

Licensed Embalmer No. *40*.....

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.