

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3111

State File No. \_\_\_\_\_

Registrar's No. **592**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY <b>City</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Res 5409 Cabanne Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>5409 Cabanne Ave.</b>	
3. NAME OF DECEASED a. (First) <b>MISS VIRGINIA</b> (Type or Print)		b. (Middle) <b>(NMI)</b>	
c. (Last) <b>WILSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 17, 1956</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Never Married <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1883</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Corry, Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Hugh M. Wilson</b>	
13b. MOTHER'S MAIDEN NAME <b>Cornelia Duffield</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Grace Vivian Wilson</b>		ADDRESS <b>5409 Cabanne</b>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> <b>Arterial hypertension</b> DUE TO (b) <b>Arterial Hypertension</b> <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> 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"/>		<b>331x</b>	
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? _____	
22. I hereby certify that I attended the deceased from <b>Nov</b> , 19 <b>1949</b> to <b>Oct</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Oct</b> , 19 <b>55</b> , and that death occurred at <b>12:00</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Francis B. Ritchie</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>5233 Waterman</b>	
23c. DATE SIGNED <b>1-17-56</b>		23d. SIGNATURE <b>Francis B. Ritchie M.D.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Jan 19, 1956</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 18 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons, Inc.</b>		ADDRESS <b>6175 Delmar</b>	

**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 *J. S. E. McCallister*.....

Licensed Embalmer No. *2460*.....

P. O. Address *6175 Pell*.....

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.