

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14987

State File No.

FILED APR 26 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3570**

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 St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			
e. STREET ADDRESS 27		(If rural, give location) 2801 Dayton Street	

3. NAME OF DECEASED (Type or Print)		a. (First) Thelma		b. (Middle)		c. (Last) Wilson		4. DATE OF DEATH (Month) 4 (Day) 5 (Year) 56	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 5-3-1941		9. AGE (In years last birthday) 14 IF UNDER 1 YEAR Months 11 Days 2 IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl				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 Charlie Wilson		13b. MOTHER'S MAIDEN NAME Rosa Lee Dover		14. NAME OF HUSBAND OR WIFE None	
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. ?		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rosa Lee Wilson 2801 Dayton 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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Paralysis; Spinal Anesthesia; Ruptured retro cecal appendicitis; while under anesthetic preparatory to operation at Homer G. Phillips Hospital on April 5th 1956.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS contributing to the death but not related to the disease or condition causing death.		DUE TO (b)		DUE TO (c)	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 5th 1956.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Asap		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Apr 5 56 ? m.		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:00** m., from the causes and on the date stated above.

23a. SIGNATURE Deputy [Signature]		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4/10/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-12-56		24c. NAME OF CEMETERY OR CREMATORY Father Dickson	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri					

DATE REC'D BY LOCAL REG. APR 10 1956		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St	
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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. 52 working under my personal supervision..

Student Oswald James
Signature of Student Embalmer

Signed Fulton E. Culter

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.