

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29335

FILED SEP 6 1956

1645-85-56

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7766**

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

3300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE - <b>Mo</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>		Length of stay in 1b	d. STREET ADDRESS <b>23 2819 HENRIETTA</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle Last <b>WILSON</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>21</b> Year <b>1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 21, 1956</b>	9. AGE (In years last birthday) <b>0</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>2</b> Min. <b>20</b>
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 country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOHN WILSON</b>			14. MOTHER'S MAIDEN NAME <b>ERMA BREWER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>ST. LOUIS CITY HOSPITAL RECORDS</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nonviable fetus</b> DUE TO (b) <b>Premature delivery</b> DUE TO (c) <b>776x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>1515 LAFAYETTE AVE.</b>		COUNTY STATE
21. I attended the deceased from <b>7/21/56</b> to <b>7/21/56</b> and last saw her alive on <b>7/21/56</b> Death occurred at <b>10:20 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. B. Avery</b> (Degree or title) <b>M.D.</b>			22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>7/27/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>8-31-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical House</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Howland-Aker Mortuary Service</b> 4104 Manchester Ave. St. Louis 10, Mo.			25. DATE RECD. BY LOCAL REG. <b>AUG 21 1956</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b> S.P.

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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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
(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.