

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19465

STATE FILE NUMBER 5051

FILED JUN 7 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

5. 300
7. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 MISSOURI b. COUNTY MONTGOMERY CO.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS MO.		c. CITY OR TOWN BELLEFLOWER	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO BAPTIST HOSPITAL		d. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) First MIDDLE Last NETTIE BARRON WILSON		4. DATE OF DEATH Month Day Year MAY 29 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 13 1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		9b. KIND OF BUSINESS OR INDUSTRY AT HOME	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME THOMAS RUSSELL		14. MOTHER'S MAIDEN NAME NANNIE DE GARMO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LUCILLE SNARR		Address ST LOUIS MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ 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 1 mo. 6 mos.
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.) 331X	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		20f. COUNTY STATE	
21. I attended the deceased from <u>4-24-57</u> to <u>5-29-57</u> and last saw her alive on <u>5-28-57</u> Death occurred at <u>2:20 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated			
22a. SIGNATURE (Degree or title) <u>Richard A. Fowler MD</u>		22b. ADDRESS <u>3720 Washington</u>	
22c. DATE SIGNED <u>5-29-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 5-29-57	
23c. NAME OF CEMETERY OR CREMATORY NEW PROVIDENCE CEM		23d. LOCATION (City, town, or county) (State) BELLEFLOWER MO.	
24. FUNERAL DIRECTOR Jones Funeral Home, Belleflower, Mo.		25. DATE RECD. BY LOCAL REG. MAY 29 57	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>			

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. (If 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.