

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34323
STATE FILE NUMBER
9037

FILED OCT 4 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
1-57 0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY OR TOWN <i>St. Louis Mo.</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>02 Alexian Bro. Hosp. 1 day</i> Length of stay in lb <i>24</i>		d. STREET ADDRESS (If outside, give location) <i>2867 Indiana</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>John H. Wilson</i>			4. DATE OF DEATH Month Day Year <i>Sept. 25 1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/22/1888</i>
9. AGE (In years last birthday) <i>68</i>		9. AGE (In years last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>John Wilson</i>	
13b. MOTHER'S MAIDEN NAME <i>Katherine Bell</i>		14. NAME OF HUSBAND OR WIFE <i>Minnie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>493-09-8505</i>	17. INFORMANT Address <i>Mo. M. Wilson 2867 Indiana</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>491X</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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		COUNTY STATE	
21. I attended the deceased from Death occurred at <i>8 P.M.</i>		and last saw her alive on <i>Sept 25 57</i> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>H. S. Fyne M.D.</i> (Degree or title)		22b. ADDRESS <i>27.52 Chamber</i>	
22c. DATE SIGNED <i>9-27-57</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>Sept. 28 '57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lake Charles Burial Pt.</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo.</i>	
24. FUNERAL DIRECTOR <i>Jos. A. Howard 1619 So. Grand</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>SEP 27 57</i>	
26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must use only standard nomenclature in item 16. No symptoms will be listed. All diseases in Part I must be causally related.

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 W M B*
Embalsmer

Licensed Embalmer No. *7653*

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.