

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38363**
Registrar's No. **9393**

FILED OCT 21 1957

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9393	
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 TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 35		c. CITY OR TOWN ST. LOUIS 2219 0		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION D.O.A. Homer G. Phillips Hospital				• STREET ADDRESS (If rural, give location) 1156 N. Leonard Ave.			
3. NAME OF DECEASED (Type or Print) ISAIAH		a. (First)		b. (Middle)		c. (Last) WILSON	
4. DATE OF DEATH Oct. 6 1957		5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Dec. 10, 1896		9. AGE (in years last birthday) 60		IF UNDER 1 YEAR Days 9		IF UNDER 24 HRS. Hours Min. 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Eggett & Meyers		11. BIRTHPLACE (City and State or Foreign Country) Tiplersville, Miss.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Jim Wilson		13b. MOTHER'S MAIDEN NAME Laura Thomas		14. NAME OF HUSBAND OR WIFE -			
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. 494-01-1357		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Wilson 4026a Labadie Ave.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia (Left Lung) 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 Conditions contributing to the death but not related to the disease or condition causing death. 527.0				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE Patrick E. Taylor-Coroner (or title)				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 10/8/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 12, 1957		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. OCT-8-57		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 Bell Ave.			

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

(Licensed Embalmer's Statement on Reverse Side)

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 *E. H. Harris*.....

Licensed Embalmer No. *445*

P. O. Address *4181 Wash*.....

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.