

Health, & Welfare  
S. Public  
th Service  
S. 300  
V. 156  
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

FILED JAN 7 1958

STANDARD CERTIFICATE OF DEATH

46646  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3230

1. PLACE OF DEATH a. COUNTY <u>St. Louis Clayton County Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>4071 Kinlock Park</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>County Hospital</u>		Length of stay in 1b <u>12 days</u>	d. STREET ADDRESS (If outside, give location) <u>8523 Scudder Ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Aline</u> Middle <u>Bryant</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>57</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-1918</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Columbus Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Sargent Bryant</u>			14. MOTHER'S MAIDEN NAME <u>Callie Sims</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Trene Sims</u> Address <u>1733 Carver Lane</u>		
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>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to above cause: (a) <u>Cardiac Insufficiency</u> stating the underlying cause last. DUE TO (b) <u>Arteriolar nephrosclerosis</u> DUE TO (c) _____ PART II; OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>442X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>11/5/57 to 12/17/57</u>
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		COUNTY _____ STATE _____
21. I attended the deceased from <u>11-05-57</u> to <u>12-17-57</u> and last saw her/him alive on <u>12-17-57</u> . Death occurred at <u>12:55 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Angelo A. Speno M.D.</u>			22b. ADDRESS <u>601 So. Brentwood</u>		22c. DATE SIGNED <u>12/18/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-22-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dixon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>County Mo</u>
24. FUNERAL DIRECTOR <u>Gus Howie</u>		ADDRESS <u>2930 Dickson St</u>		25. DATE RECD. BY LOCAL REG. <u>12-23-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Donahue</u>

(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 *Arthur L. Hilliard*

Licensed Embalmer No. *429*

P. O. Address *3100 E. 1st*

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.