

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1958

58-012473

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2944

300  
1-57

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</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>04 BARNES HOSPITAL</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2210 2808 WASHINGTON</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>NMN</b> Last <b>WESLEY</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>1958</b>				
5. SEX <b>3 FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-2-1904</b>	9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAID</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE FAMILY</b>		11. BIRTHPLACE (City and state or country) <b>HARRISTON MISS.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>CHARLIE HALL</b>		13b. MOTHER'S MAIDEN NAME <b>NORA BAILEY</b>			
14. NAME OF HUSBAND OR WIFE <b>JOHN WESLEY</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.			
17. INFORMANT <b>JOHN WESLEY</b>		Address <b>2808 WASHINGTON</b>		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>ENCEPHALOPATHY</b> DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> 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) <b>RENAL FAILURE 2 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>8 YEARS</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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 Month, Day, Year 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>ST LOUIS MO.</b>		20g. COUNTY		20h. STATE			
21. I attended the deceased from <b>FEB. 8, 1958</b> to <b>MARCH 10, 1958</b> and last saw her alive on <b>MARCH 10, 1958</b> Death occurred at <b>8:05 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>C. C. Vermillion, M.D.</i> (Degree or title)			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>3/10/58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>3-17-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN WOOD</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MO.</b>		
24. FUNERAL DIRECTOR <i>Bessie Love</i>		ADDRESS <b>3103 Washington</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 13 58</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i> <b>MRS.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. 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 *W. Claude Gordon* .....

Licensed Embalmer No. *3489* .....

P. O. Address *4575 Aldin* .....

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.