

XC-5829446 SL 16455

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038346

STATE FILE NUMBER

10286

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10286

FILED NOV 10 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>915 N.GRAND ST. LOUIS, MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>IBERIA</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>VET. ADM. HOSPITAL</u>		Length of stay in lb <u>4 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>31</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>BENNY</u> Middle <u>A.</u> Last <u>WILSON</u>			4. DATE OF DEATH Month <u>10/</u> Day <u>26/</u> Year <u>58</u>
5. SEX <u>MALE</u> <u>0</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-23</u>
9. AGE (In years last birthday) <u>35</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER & LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	11. BIRTHPLACE (City and state or country) <u>BRAYS, MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>LAWRENCE WILSON</u>	
13b. MOTHER'S MAIDEN NAME <u>SARAH DUKE</u>		14. NAME OF HUSBAND OR WIFE <u>MARIE WILSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>YES</u> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>VAH RECORDS</u>		Address <u>915 N.GRAND ST. LOUIS, MO.</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>CONGESTIVE HEART FAILURE</u> <u>RHEUMATIC HEART DISEASE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ACUTE BACTERIAL ENDOCARDITIS</u> DUE TO (c) <u>401.1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u> <u>11 YEARS</u> <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-</u>			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"/> <u>none</u>		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 <u>IBERIA, MO.</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>10/22/58</u> to <u>10/26/58</u> and last saw him live on <u>10/26/58</u> Death occurred at <u>7:25 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. S. Sly</u> (Degree or title) <u>0</u>		22b. ADDRESS <u>M.D. VAH 915 N.GRAND ST. LOUIS, MO.</u>	
22c. DATE SIGNED <u>10/27/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-27-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WILLIAM S. SLY, M.D. Local</u>		23d. LOCATION (City, town, or county) (State) <u>Iberia, Mo.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u>		ADDRESS <u>4700 Washington, Blvd.</u>	
25. DATE RECD. BY LOCAL REG. <u>OCT 27 58</u>		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> <u>JP</u>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

100 26 APR

VS NOV 17 1960

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 *John J. Fairie*
Licensed Embalmer No. *4108*
P. O. Address *W. Hill*

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.