

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003648

STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **599**

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1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3655 SHENANDOAH		Length of stay in lb 6 YRS	d. STREET ADDRESS (If outside, give location) 3655 SHENANDOAH
3. NAME OF DECEASED (Type or print) CECELIA ANN WILSON		First Middle Last	4. DATE OF DEATH Month Day Year JAN. 16, 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		9b. KIND OF BUSINESS OR INDUSTRY RETIRED DRY GOODS	9. AGE (In years at birth) 76
10a. FATHER'S NAME HENRY MILLER		10b. BIRTHPLACE (City and state or country) E. ST. LOUIS, ILL.	10. CITIZEN OF WHAT COUNTRY? U. S. A
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		11. SOCIAL SECURITY NO. 329-10-3132	12. NAME OF HUSBAND OR WIFE MELVIN L WILSON DECEASED
12. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Galeric Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 6 YRS 4 Mos.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis		6 YRS 4 Mos.	
DUE TO (c) Hypertension		6 YRS 4 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 444X		
20c. TIME OF INJURY Hour Month, Day, Year a.m. 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 Sept 16-1952 to Jan 16, 1959 and last saw her alive on Jan 9, 1959 Death occurred at Jan 16 1959 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Harry L Heidenreich M.D.		22b. ADDRESS 3750 Gravois St. St. Louis, Mo.	22c. DATE SIGNED 1-17-1959
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1-19-59	23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL	23d. LOCATION (City, town, or county) (State) BELLEVILLE ILL
24. FUNERAL DIRECTOR Nell Ralph Barnes F1295 C. ST. LOUIS, ILL.		25. DATE RECD. BY LOCAL REG. JAN 17 '59	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. m. s. B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *John Maher*

Licensed Embalmer No. *29-8294*

P. O. Address *E. ST. LOUIS, ILL.*

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.