

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011753

STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 879

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Groves</b> <sup>4617</sup> <sub>0</sub>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>307 Edgar Rd.</b>		Length of stay in 1b <b>At home</b>	d. STREET ADDRESS (If outside, give location) <b>307 Edgar Rd.</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CHEYNEY</b> Last <b>WILSON</b>			4. DATE OF DEATH Month <b>Apr.</b> Day <b>1</b> Year <b>1959</b>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>Oct. 9, 1883</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroads</b>	11. BIRTHPLACE (City and state or country) <b>Toledo, Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William A. Wilson</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Vandivere</b>	14. NAME OF HUSBAND OR WIFE <b>Genevieve Wilson</b>
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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. <b>702-05-0192</b>	17. INFORMANT Address <b>Genevieve Wilson, 307 Edgar Rd.</b>
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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>Cerebral Haemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arterio-sclerosis</b>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.) <b>None</b>
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20c. TIME OF INJURY Hour <b>None</b> Month <b>None</b> Day <b>None</b> Year <b>None</b>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. CITY, TOWN, OR LOCATION <b>None</b>	COUNTY <b>None</b>	STATE <b>None</b>
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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.) <b>None</b>	20f. CITY, TOWN, OR LOCATION <b>None</b>	COUNTY <b>None</b>	STATE <b>None</b>
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21. I attended the deceased from <b>many years</b> to <b>3/31/59</b> and last saw her alive on <b>3/31/59</b> Death occurred at <b>3:20 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <b>Frank P. Gaunt M.D.</b>	22b. ADDRESS <b>13<sup>th</sup> N. Elm Webster Groves Mo</b>	22c. DATE SIGNED <b>4/1/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-3-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kirkwood, Mo.</b>
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24. FUNERAL DIRECTOR <b>Parker-Aldrich, Webster Groves</b>	ADDRESS <b>Webster Groves</b>	25. DATE RECD. BY LOCAL REG. <b>4-1-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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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 *Lucie Welch* .....

Licensed Embalmer No. *4395* .....  
P. O. Address *Whiter Grove* .....

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.