

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015975

STATE FILE NUMBER  
2690

FILED MAY 1 1959 Registration District No. Primary Registration District No. Registrar No.

300  
1-57  
2-57  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>5461 Cabanne Ave.</b>	
Length of stay in lb <b>46yrs</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>GRACE VIVIAN WILSON</b>			4. DATE OF DEATH Month Day Year <b>March 14, 1959</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1876</b>	9. AGE (In years on birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher Soldan HighSch, Garland, Pennsylvania</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Garland, Pennsylvania</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Hugh M. Wilson</b>	13b. MOTHER'S MAIDEN NAME <b>Cornelia Duffield</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>no none</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Miss Grace V Wilson</b>	Address <b>5461 Cabanne Ave</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>Arteriosclerotic coronary disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-6 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>420.1</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) <b>Septicemia of colon with partial obstruction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from <b>11/22/58</b> to <b>3/14/59</b> and last saw her/him alive on <b>3/14/59</b> Death occurred at <b>4:55 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Robert Parrie</b>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>3720 Washington Blvd.</b>	22c. DATE SIGNED <b>3/16/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremations</b>	23b. DATE <b>3/17/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>Alexander &amp; Sons</b>	ADDRESS <b>6175 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 17 '59</b>	26. REGISTRAR'S SIGNATURE <b>Neal Smith M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Joseph E. McCulloch* .....

Licensed Embalmer No. *2460* .....

P. O. Address *6150 Elm* .....

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.