

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019770
STATE FILE NUMBER
2 4460

FILED MAY 18 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
1-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION E/R To City Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5042 Washington Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES H. WILDER			4. DATE OF DEATH Month Day Year May 4, 1959
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years from birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 76 Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Flora, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME W.W. Wilder		13b. MOTHER'S MAIDEN NAME Tempa Wilder	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-10-6242	17. INFORMANT Address Oscar Sasseen, 5750 Waterman
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>Arteriosclerotic Heart Disease with Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis, general</u> DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.) 420.0	
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 checked="" 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 <u>Dec 6 1957</u> and last saw her alive on <u>May 2, 1959</u> Death occurred at <u>5:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		21. I attended the deceased from <u>Dec 6 1957</u> and last saw her alive on <u>May 2, 1959</u> Death occurred at <u>5:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Joseph C Carney M.D.</u> (Degree or title)		22b. ADDRESS <u>906 Olive St</u>	
22c. DATE SIGNED <u>5-6-59</u>		22c. DATE SIGNED <u>5-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>
23d. LOCATION (City, town, or county) (State) <u>Marion, Illinois</u>		23d. LOCATION (City, town, or county) (State) <u>Marion, Illinois</u>	
24. FUNERAL DIRECTOR <u>McLAUGHLIN'S, 2301 Lafayette Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 6 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc., must use only standard nomenclature as given to - 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 H. G. Farris

Licensed Embalmer No. 3384

P. O. Address H. Louis

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.