

# JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 22 1959

59-034609

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2493

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ST LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON MO</u> Length of stay in 1b <u>4 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSPITAL</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> c. CITY OR TOWN <u>ELMWOOD PARK</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9417 ROTHWELL</u> Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ELIZABETH</u> Middle <u>WILSON</u> Last <u>WILSON</u>			<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>14</u> Year <u>1959</u>				
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>NEGRO</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>MAY 1 1891</u>	<b>9. AGE (last birthday)</b> <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DOMESTIC</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>CHESTER ILL</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>ROBERT WILSON DECEASED</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>		<b>17. INFORMANT</b> Address <u>Mrs. Koch 9417 Rothwell</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIDLAR NEPHROSCLEROSIS, SEVERE, UNKNOWN</u> <u>BILAT.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GENERALIZED ARTEROSCLEROSIS E.H.C.D., TRACHEOBRONCHITIS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>GREATER THAN 1 YEAR</u>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <u>9-10-1959</u> to <u>9-14-1959</u> and last saw her/him alive on <u>9-14-1959</u> Death occurred at _____ <u>6pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Ronald C. Johnson M.D.</u>			<b>22b. ADDRESS</b> <u>601 S. B rentwood, Clayton, Mo.</u>			<b>22c. DATE SIGNED</b>	
<b>23a. BURIAL CREMATION RENEWAL</b> (Specify) <u>Final Sep 19, 1959</u>		<b>23b. DATE</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenwood Cemetery St Louis</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Mo</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>J. J. Gardner &amp; Sons 177 East Hickman</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-16-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy M.D.</u>			

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Heather P. Vandee*

Licensed Embalmer No. 4245

P. O. Address 1306 Elder  
Wester 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.