

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042708

FILED VS DEC 11 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211055**

RECEIVED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		length of stay in lb 12 yrs. 4 Mos. 10 da.		c. CITY OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4301 Strodtman Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle George Last WILKERSON				4. DATE OF DEATH Month November Day 28th , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-27-02	9. AGE (last birthday) 56 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) formerly: Welder		10b. KIND OF BUSINESS OR INDUSTRY Granite City Steel		11. BIRTHPLACE (City and state or country) Jefferson City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME unknown			13b. MOTHER'S MAIDEN NAME Minnie Ritter		14. NAME OF HUSBAND OR WIFE Pauline Wilkerson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 494-10-1420		17. INFORMANT Address Mary Barrale 1924 a N. Market St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Peritonitis, acute, with effusion							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) Chronic catarrhal colitis of liver							
DUE TO (c) Chronic catarrhal colitis, old							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary tuberculosis, old Laennec's cirrhosis of liver General paresis of insane						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	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
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 July 18, 1947 to Nov. 28, 1959 and last saw him alive on Nov. 28-1959				Death occurred at 7:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L. Hofstatter, M.D. (Degree or title)			22b. ADDRESS 5400 Arsenal St.			22c. DATE SIGNED 11-30-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/1/1959	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemet.		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)	
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis Ave.			25. DATE RECD. BY LOCAL REG. NOV 30 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. S.P.		

DECEASED'S DUE TO PERFORATED ULCER
 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 Gustav W. Dietrich

Licensed Embalmer No. 4329

P. O. Address St Louis Mo

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.