

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-042719

STATE FILE NUMBER

FILED VS NOV 3 0 1959

210474

Registration District No. Primary Registration District No. Regis.

V.S. 300
Rev. 1-56
38
244

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY HOSP N°1</u> Length of stay in lb <u>DOR</u>		d. STREET ADDRESS (If outside, give location) <u>920 LYNCH ST</u> Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANGELA</u> Middle <u>CHRISTINE</u> Last <u>WILSON</u>		4. DATE OF DEATH <u>NOV-12-1959</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG-18-1959</u>
9. AGE (In years last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u>0</u> Mins. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WINSTON I. WILSON</u>	
14. MOTHER'S MAIDEN NAME <u>LORETTA JOHNSON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>WINSTON WILSON</u> Address <u>920 LYNCH ST. ST LOUIS MO</u>	
18. CAUSE OF DEATH [Enter only one cause per life for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to enlarged Thyroid Gland</u> DUE TO (b) <u>Thyroiditis pneumonia in right upper lobe and bilateral atelectasis</u> DUE TO (c) <u>atelectasis</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 checked="" type="checkbox"/> NO <input type="checkbox"/>			<u>273X</u>
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.) <u>∅</u>
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 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>7:45 P</u> to <u>8:00 P</u> and last saw her alive on <u>11-13-59</u> Death occurred at <u>7:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Patrick Taylor Coroner</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>11.13.59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Nov-14-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LEMAY, MO</u>
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME</u> ADDRESS <u>MEHLVILLE MO</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 13 1959</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>

mjc

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 *W E Morris*.....

Licensed Embalmer No. *336*.....

P. O. Address *St 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.