

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-004653**

**FILED VS JAN 11 1960**

**317**

Registration District No. **500** Primary Registration District No. **500**

Registrar's No. **2**

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	<b>St. Louis</b>	a. STATE	<b>Missouri</b> COUNTY <b>St. Louis</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN	<b>Cool Valley</b>	c. CITY OR TOWN	<b>Cool Valley</b>
	Length of stay in lb		Inside Limits
	<b>5 Yrs.</b>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	<b>1246 Wilaba Dr.</b>	d. STREET ADDRESS (If outside, give location)	<b>1246 Wilaba Dr.</b>
	Inside Limits		Reside on Farm
	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First	Middle	Last	Month	Day
<b>Malcolm Wilson</b>			<b>1-1-60</b>	Year
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)
<b>Male</b>	<b>White</b>		<b>5-12-08</b>	<b>51</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
<b>Vice President</b>		<b>Biltmoor Moving</b>	<b>Sikeston, Missouri</b>	<b>USA</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	
<b>John W. Wilson</b>		<b>Ida Stokes</b>	<b>Wanda Szuba Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address	
<b>No</b>		<b>None</b>	<b>493-09-9418 Allen Wilson Cool Valley, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	<b>Acute Coronary Thrombosis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis mild</b>	<b>since May 18, 1959</b>
	DUE TO (c) <b>Osteomyelitis Right leg</b>	<b>since July 12, 1957</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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.)
20c. TIME OF INJURY	Hour	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 <b>May 24, 1948</b> to <b>Jan 1, 1960</b> and last saw him alive on <b>July 23, 1959</b>
Death occurred at <b>11:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
<b>Leo P. Fitz Gerald M.D.</b>		<b>6677 Delmar University City Mo</b>	<b>Jan 2, 1960</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>1-4-60</b>	<b>Memorial Park Cem.</b>	<b>St. Louis County, Mo.</b>

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>White-Mullen</b>	<b>118 N. Florissant Rd.</b>	<b>JAN 2 1960</b>	<b>John C. Murphy M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 19

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Reinhold K Lohman

Licensed Embalmer No. 3395

P.O. Address St Louis 3

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.