

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009288

FILED VS MAR 3 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590-500 Registrar's No. 604

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u>		Length of stay in 1b <u>7yrs. 6 mos.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>9 Crestwood Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MARGARET</u> Last <u>WILSON</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1960</u>		
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>3-11-81</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOM</u>	11. BIRTHPLACE (City and state or country) <u>Louisville, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Philip C. Bond</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Miller</u>		14. NAME OF HUSBAND OR WIFE <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>Son-Dr. Keith Wilson</u> <u>9 Crestwood Drive, Clayton, Mo.</u>	

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 Years
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>			Years
DUE TO (b) <u>Generalized Arteriosclerosis</u>			Years
DUE TO (c) <u>Osteoarthritis</u>			Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Essential Hypertension</u> <u>Chronic Brain Syndrome due to Senile Brain Disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>	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>Aug. 1, 1952</u> , to <u>Feb. 22, 1960</u> last saw ^{her} _{him} <u>live</u> on <u>2-22-60</u> Death occurred at <u>7:00 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>	22c. DATE SIGNED <u>2/22/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-25-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis Co, MO</u>

24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Sono-7233 Adams</u>	25. DATE RECD. BY LOCAL REG. <u>2-23-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence H. Mur

Licensed Embalmer No. 4011

P. O. Address H. Lewis

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.