

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 5 1960

60-013417

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STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>32 hrs.</b>	c. CITY OR TOWN <b>Paducah</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Glennon Memorial Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2100 Dixie Ave.</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>Rickie Wilson</b>	First Middle Last	4. DATE OF DEATH <b>March 24, 1960</b>	Month Day Year
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/55</b>	9. AGE (last birthday) <b>5</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>McCracken Co., Ky.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>Harold Wilson</b>	13b. MOTHER'S MAIDEN NAME <b>Geneva Webb</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Harold Wilson, Paducah, Ky.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO (b) <b>Pleural effusion Anasarca</b> DUE TO (c) <b>Nephrotic Syndrome</b>	INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension Severe. 591X</b>	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
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from **March 23, 1960**, to **March 24, 1960** and last saw him alive on **March 24, 1960**  
Death occurred at **11:20 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <b>John B. Sumner, M.D.</b>	22b. ADDRESS <b>#16 Hampton Village Plaza</b>	22c. DATE SIGNED <b>3/25/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-28-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Garden</b>	23d. LOCATION (City, town, or county) (State) <b>McCracken Co., Ky.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 28 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

In Hospital 3 hrs

*m d b*

**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 Elton H. Penick

Licensed Embalmer No. 428

P. O. Address St. Don

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.