

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017479

FILED VS. MAY 13 1960

2 4390

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Wash.</i>	
b. CITY (If outside corporate limits, give TOWNSHIP) OR TOWN <i>St. Louis, Missouri</i>		c. CITY OR TOWN <i>Potosi</i>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>BARNES HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>505 Austin</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>CLARA ELLEN WILSON</i>			4. DATE OF DEATH Month Day Year <i>April 23, 1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>10-18-1891</i>
9. AGE (last birthday) <i>69</i>		IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Potosi, Mo. (Wash)</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		13a. FATHER'S NAME <i>William Thomas Wilson</i>	
13b. MOTHER'S MAIDEN NAME <i>Unknown</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Blanche Corder</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Metastatic Carcinoma of the right colon</i> DUE TO (c) <i>153.0</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>2 mos.</i>
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 checked="" 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 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 <i>April 12, 1960</i> to <i>April 23, 1960</i> and last saw her <i>xxx</i> live on <i>April 23, 1960</i> Death occurred at <i>3:30 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Type or print) <i>Gabriel H. Smith M.D.</i>		22b. ADDRESS <i>BARNES HOSPITAL</i>	
22c. DATE SIGNED <i>4/23/60</i>		23. LOCATION (City, town, or county) (State) <i>Potosi, Wash. Mo</i>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>BURIAL</i>	23b. DATE <i>Apr. 26-60</i>	23c. NAME OF CEMETERY, OR CREMATORY <i>Sun Set Hills</i>	
24. FUNERAL DIRECTOR <i>Sparks</i>		25. DATE RECD. BY LOCAL REG. <i>APR 23 1960</i>	
ADDRESS <i>301 E. High Potosi</i>		26. REGISTRAR'S SIGNATURE <i>Gabriel Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 13 1960  
STATEMENT BY LICENSED EMBALMER

MAY 19 1960

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 Ronald P. Sparks

Licensed Embalmer No. 481

P. O. Address 301 E. High

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.