

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021705

FILED VS MAY 25 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 4567 STATE FILE NUMBER

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>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Faith Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2320 Warren</u>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/1937</u>	9. AGE (last birthday) <u>23</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Samuels Shoe Co.</u>		11. BIRTHPLACE (City and state or country) <u>Success, Ark.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>Don Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Gusta Hovas</u>		
				14. NAME OF HUSBAND OR WIFE <u>Irene Wilson</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>489-36-9671</u>	17. INFORMANT <u>Irene Wilson, 2320 Warren</u>
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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) <u>Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
DUE TO (b) <u>metastasis to lung + liver</u>		
DUE TO (c) <u>1784</u>		
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 _____ a.m. _____ p.m.	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 <u>Doniphan, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from March 1, 1960 death and last saw her/him alive on 4-28-60
Death occurred at approx 2:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J.M. Linton M.D.</u> (Degree or title)	22b. ADDRESS <u>3400 N. Kingshighway</u>	22c. DATE SIGNED <u>4-29-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Doniphan, Mo.</u>
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 29 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>S.P.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF TEXAS

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

HEALTH CARE SERVICES

HEALTH CARE SERVICES

OFFICE OF THE DIRECTOR

HEALTH CARE SERVICES

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HEALTH CARE SERVICES

STATE OF TEXAS

HEALTH CARE SERVICES

HEALTH CARE SERVICES

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HEALTH CARE SERVICES

MAR 24 1961

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 Flourno M. Billo
Licensed Embalmer No. 4375
P. O. Address St. Louis, 23,

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