

OUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035130

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8530 STATE FILE NUMBER

AMENDED

FILED SEP 21 1961

STATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. # 1 Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2411 Dickson St.</u>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L.</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>5-27-27</u>
9a. AGE (last birthday) <u>34</u>	9b. IF UNDER 1 YEAR Months <u>10</u> Days <u>6</u>		9c. IF UNDER 24 HR Hours <u>1</u> Min.
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>None</u>	11. BIRTHPLACE (City and state or country) <u>Mississippi</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Alric Virgie</u>	
13b. MOTHER'S MAIDEN NAME <u>Anna Lee Wrench</u>		14. NAME OF HUSBAND OR WIFE <u>King 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>None</u>	17. INFORMANT <u>King Wilson-2411 Dickson St.</u>
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>Sub-arachnoid hemorrhage</u> DUE TO (b) <u>(Traumatic) suffered in fall in</u> DUE TO (c) <u>home - Exact date unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Enter date of onset of disease condition given in PART I (a)) <u>See above</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>See above</u>	
20c. TIME OF INJURY Hour <u>?</u> a.m. <u>?</u> p.m. <u>?</u> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>21 Home</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis</u>	COUNTY <u>Mo</u> STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>6:40 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helene L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Oakleaf Ave.</u>	22c. DATE SIGNED <u>9-13-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-14-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson Bks., Mo.</u>
24. FUNERAL DIRECTOR <u>Ellis Funeral Home-2820 Stoddard St.</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 13 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Fulton E. Culpeper

Licensed Embalmer No. 4108

P. O. Address Shaw

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.