

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039738
STATE FILE NUMBER

AMENDED Registration District 317 Primary Registration District No. 590 Registrar's No. 2995

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u> | | Length of stay in 1b <u>10 mos</u> | c. CITY OR TOWN <u>Baldwin, Mo</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cedarcroft Nurs Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>123 Shirley Lane</u> |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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| 3. NAME OF DECEASED (Type or print) First <u>ANGELINE</u> Middle <u>WILSON</u> Last <u>WILSON</u> | 4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1961</u> |
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| 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>2/14/1881</u> | 9. AGE (last birthday) <u>80</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 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>domestic</u> | 11. BIRTHPLACE (City and state or country) <u>Piedmont, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>James A Eaton</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Edgar</u> | 14. NAME OF HUSBAND OR WIFE <u>Robert Wilson (dec.)</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>Thelma Cupp 123 Shirley La. Baldwin, Mo</u> | Address <u> </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>Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Generalized arteriosclerosis</u> | | <u>2 yrs</u> |
| | DUE TO (c) <u> </u> | | <u> </u> |

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| 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 |
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| 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.) |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. | Month, Day, Year <u> </u> / <u> </u> / <u> </u> |
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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 <u> </u> COUNTY <u> </u> STATE <u> </u> |
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21. I attended the deceased from 2/10/61 to 10/24/61 and last saw her alive on 10/24/61
Death occurred at 12:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | 22b. ADDRESS <u>Kirkwood 22 Mo</u> | 22c. DATE SIGNED <u>10/24/61</u> (State) |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>10/28/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Hill Cem.</u> | 23d. LOCATION (City, town, or county) <u>Ellsinor, Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Ortmann F. Home 9222 Lackland Overland Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>10-26-61</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 Sam Stjepanovic

Licensed Embalmer No. 5088

P. O. Address _____

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.