

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-045952
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 319

AMENDED

FILED JAN 10 1962

| | | | | | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|--------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Charles</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> | | Length of stay in 1b <u>10 Yrs.</u> | | c. CITY OR TOWN <u>St. Charles</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3300 Elm St. Rd.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>3300 Elm St. Rd.</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Wilson</u> Last <u>Wilson</u> | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1961</u> | | | | | | | | | |
| 5. SEX <u>Male</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>Nov. 10, 1875</u> | | 9. AGE (last birthday) <u>86</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HR Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | | 11. BIRTHPLACE (City and state or country) <u>Nashville, Tenn.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>Unknown</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Clara Smith</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> | | | | | | 17. INFORMANT Address <u>Mr. Joseph Haake, St. Charles, Mo.</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>EVIDENT NATURAL CAUSES</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>POLICE REP. (12/31/61)</u> | | | | | | | | | | | | | |
| DUE TO (c) <u>ASST. COR. NOTIFIED.</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 <u></u> a.m. <u></u> p.m. <u></u> | | Month, Day, Year <u></u> | | | | | | | | | | | |
| 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 <u>Found</u> to <u>4 P</u> and last saw <u>her</u> <u>him</u> alive on <u></u> Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Marcella Wilson L. Reg</u> | | | | | | 22b. ADDRESS <u>902 Holly St. CHARLES</u> | | | 22c. DATE SIGNED <u>1/3/62</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Jan. 3, 1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u> | | | 23d. LOCATION (City, town, or county) <u>St. Charles, Mo.</u> | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>H.C. Dallmeyer & Sons, St. Charles, Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>Jan. 3. 62</u> | | 26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u> | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Body not embalmed.

W. J. Palmer & S.

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 _____

Licensed Embalmer No. _____

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.