

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-029328

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7659**

FILED AUG 1 3 1962

VS 300 Rev. 4/59	DATE AMENDED		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		a. STATE Missouri COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 6027 N. Lindberg	
3. NAME OF DECEASED (Type or print) First VERA Middle MAE Last WILSON		4. DATE OF DEATH Month AUGUST Day 3 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. AGE OF BIRTH Dec. 31, 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Afton, Mo.	
13a. FATHER'S NAME Willis Wilson		13b. MOTHER'S MAIDEN NAME Vera B. Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT W. Wilson, 4319 Swan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ECLAMPSIA			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
DUE TO (b) TERM PREGNANCY (CESAREAN SECTION)			9 MONTHS
DUE TO (c) 642.3			
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 checked="" 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 7:30 A.M. Month, Day, Year AUG. 2, 1962		20f. CITY, TOWN, OR LOCATION St. Louis County, Mo.	
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.)	
21. I attended the deceased from 10:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F. R. Bradley, M.D.		22c. DATE SIGNED 8/4/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 8/6/62	
23c. NAME OF CEMETERY OR CREMATORY Laural Hills		23d. LOCATION (City, town, or county) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Rowland-Ogden Mortuary,		25. DATE RECD. BY LOCAL REG. AUG 6 1962	
ADDRESS 4106 Manchester		26. REGISTRAR'S SIGNATURE Coal Smith, M.D.	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

BY AFFIDAVIT OF

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 Phillip A. Ogden

Licensed Embalmer No. 5170

P. O. Address St. Louis, Mo

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.