

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11791 -62-045092
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11791**

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 14 1962

VS 300
Rev. 4/59

1
2 **220**
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4 **0**
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13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2219 University St.				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DENNIS Middle CLAY Last WILSON JR.			4. DATE OF DEATH Month Dec Day 8 Year 1962			5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 7, 1962		9. AGE (last birthday) 1 Months 2 Days		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRT. PLACE (City and state or country) St. Louis, Missouri				12. CITIZEN OF WHAT COUNTRY USA				13a. FATHER'S NAME Dennis C. Wilson		13b. MOTHER'S MAIDEN NAME Marie Antoinette Kowalski	
14. NAME OF HUSBAND OR WIFE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Dennis Wilson 2219 University			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 776x DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
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		COUNTY STATE	
21. I attended the deceased from Dec 7, 1962 to Dec 8, 1962 and last saw him alive on Dec 8, 1962 Death occurred at 9:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Herbert J. Woods, M.D.</i> (Degree or title)						22b. ADDRESS 3534 Serrano Ave			22c. DATE SIGNED 12/8/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 10, 1962		23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery		23d. LOCATION (City, town, or county) St. Louis Missouri			23e. (State)		
24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE.						25. DATE RECD. BY LOCAL REG. DEC 10 1962		26. REGISTRAR'S SIGNATURE <i>Ronald Smith, M.D.</i>			

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

RECEIVED
DEC 1 1923

*D. R. Ruel's
Fulton Hospital*

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 *Not Embalmed*
D. R. Ruel

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.