

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

43070

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hosp #1)

File No. ....

Registered No. 12358

St. ....

(Ward)

**2. FULL NAME**

Lloyd (Woodrow) Wilson

(a) Residence. No. 4635 Evans Ave St. 11 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Alice Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

abt. 33

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Kentucky

(STATE OR COUNTRY)

10. NAME OF FATHER

V. D. Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT (Address)

Alice Wilson  
4635 Evans Ave

15.

FILED

6 18 1926

Max C. [unclear]

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 17 19 28

17.

I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... 8:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Shock & Injuries (fractures)  
Skull Struck by Auto  
in St Louis Mo

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

Accident

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. W. [unclear]  
12/20, 1928 (Address) Rep. Coroner

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Paragould Arkansas

DATE OF BURIAL

December 19 1928

20. UNDERTAKER

Chas. L. Geraghty

ADDRESS

4822 East Ave

V. S. NO. 2. PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

