

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

Do not use this space.

29216

**1. PLACE OF DEATH**

County..... Registration District No. *781*  
 Township..... Primary Registration District No. *1003*  
 City *St. Louis Mo.* (No. *City Hospital*) St. .... Ward)

File No. ....  
 Registered No. *8350*

**2. FULL NAME** *William Lee Wilson*

(a) Residence. No. *4535 Arnold Place* St. *7* Ward. ....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred *7* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <b>Married</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Agnes Wilson</b>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>Oct. 10 1877</b>		
7. AGE YEARS <b>51</b>	MONTHS <b>10</b>	DAYS <b>13</b>
If LESS than 1 day, ..... hrs. or ..... min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>Real Estate</b> (b) General nature of industry, business, or establishment in which employed (or employer) ..... (c) Name of employer .....		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 14 1929*

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 *3 B.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Septic Pneumonia due to multiple fracture of ribs. & Bar Pneumonia*

CONTRIBUTORY (SECONDARY) *cause and manner Unknown* (duration) ..... yrs. .... mos. .... ds.

9. BIRTHPLACE (CITY OR TOWN) **Coulterville** (STATE OR COUNTRY) **Ill.**

10. NAME OF FATHER **William 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**

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? DATE OF.....  
 WAS THERE AN AUTOPSY? *yes*  
 WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) *Wm. D. Wood*, M.D.  
*8/15*, 19 *29* (Address) *Coroner*

14. INFORMANT *James L. Wilson* (Address) *4535 Arnold Pl.*

15. FILED..... 19..... *May 21 1929* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Coulterville Ill.** DATE OF BURIAL **8/16 1929**

20. UNDERTAKER *Burns Bros.* ADDRESS *Coulterville Ill.*

PARENTS

