

OCT 18 1934

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

Do not use this space.

31664

1. PLACE OF DEATH

County *St. Louis*

Township *East*

City

(No.)

St.

Ward)

Registration District No. *836*

Primary Registration District No. *6100*

File No. *66*

Registered No. *66*

2. FULL NAME *Baby Wilson*

(a) Residence, No.

St.

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 *M*

4. COLOR OR RACE *W*

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 29, 1934*

7. AGE

YEARS

MONTHS

DAYS

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

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *nil*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

FATHER

13. NAME *Robert Wilson*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Okla*

MOTHER

15. MAIDEN NAME *Lillian Rice*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Robert Wilson*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Home yard* DATE *Aug 30, 1934*

19. UNDERTAKER (ADDRESS) *None*

20. FILED *9/21, 1934* *Florence Wilson* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 30, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Aug 29, 1934* to *Aug 30, 1934*

I last saw him alive on *Aug 29, 1934*. Death is said to have occurred on the date stated above, at *5:00* m.

The principal cause of death and related causes of importance were as follows:

Primiture
15 19
15 9

Other contributory causes of importance

Name of operation Date of
What test confirmed diagnosis *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify *Rosa Lyles, manager*
(Signed) *Conno mo*
(Address)

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.

