

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.

REG'D OCT 14 1939 791
Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: **1003**
 (a) County 1
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Since 7/8/39
 (Specify whether _____)
 In this community _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St. Louis 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4228 St. Ferdinand
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME 425 Ella Wilson
 (b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 7
 year 1939 hour 6 minute 50 a. M.

4. Sex F 5. Color or race C
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife James Wilson (c) Age of husband or wife if alive 44 1/2 years
 7. Birth date of deceased March 25, 1900
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7/8/39
 _____, 19____, to 9/7/39, 19____;
 that I last saw her alive on Sept. 7, 1939
 and that death occurred on the date and hour stated above.
 Immediate cause of death Chronic nephritis with Duration 3-4 yrs
hypertension

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>5</u>	<u>12</u>	_____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

9. Birthplace Mississippi
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housework

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 MOTHER FATHER {
 12. Name Cal Cosby
 13. Birthplace Mississippi
 (City, town, or county) (State or foreign country)
 14. Maiden name Annie Baker
 15. Birthplace Mississippi
 (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant's own signature JAS Wilson
 (b) Address 4228 St. Ferdinand, Cal.
 17. (a) _____ (b) Date thereof SEPT 11, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation WASHINGTON PARK
 18. (a) Signature of funeral director Adams Undertaking
 (b) Address 3849 Windsor Pl
 19. (a) SEP 10 1939 (b) J. F. Bredeck
 (Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature H. J. Lyman (M. D. or D. O.)
 Address 2601 N Whittier Date signed 9/8/39

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.....

J. A. Brown....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. A. Brown*.....
Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin*

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 this body is not embalmed, above space should be left blank.