

U. S. No. 2
M-11-10-39
Rev. 5-17-39
I X21492

FILED APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9360
Registrar's No. 2843

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(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 G. Phillips Hosp.
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution 30 Hrs., 40 Min.
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County _____
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2606a Thomas
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

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

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased 2-29-40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1
If less than one day 30 hr. 40 min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name unk unk
13. Birthplace unk unk
(City, town, or county) (State or foreign country)
14. Maiden name Florence Wilson
15. Birthplace Lebanon Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant brother Mary Howard
(b) Address 2601 N Whittier
17. (a) burial (b) Date thereof 3-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ara Hamilton
(b) Address City Health Dept
19. (a) MAR 27 1940 (b) _____
(Date received by registrar) (Signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 3- day 1-
year 1940 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from 2-29- 1940 to 3-1- 1940
that I last saw him alive on 3-21- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis Neonatorum
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy Atelectasis Neonatorum

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature J. E. Peace (M. D. or other) 3-25-40
Address 2601 N Whittier Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

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