

FILED MAR 6 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2037**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
City Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year 7 mo. 3 days  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. no home  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country American

3. (a) PRINT FULL NAME James Wilson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Colored 5. Color or race Black

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24, year 1944, hour 11:55 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Feb 24, 1944 to Feb 24, 1944  
that I last saw him alive on Feb 24, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: chronic myocarditis  
Duration: several years

8. AGE: Years alt 70 Months K Days X If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation: Unknown

11. Industry or business: unknown

12. Name: unknown

13. Birthplace: unknown (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name: \_\_\_\_\_

15. Birthplace: unknown (City, town, or county) \_\_\_\_\_ (State or foreign country)

Due to: general arteriosclerosis

Due to: \_\_\_\_\_

Other conditions: 93  
(Include pregnancy within 3 months of death)

Major findings: Of operations: \_\_\_\_\_

Of autopsy: none

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

MOTHER FATHER

16. (a) Informant: Tommie Green  
(b) Address: 5800 Arsenal  
Antoine Board (c) Date thereof: 2-29-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director: W. Richter  
(b) Address: FEB 29 1944  
3rd St. St. Louis

19. (a) (Date received local registrar) \_\_\_\_\_ (b) (Registrar's signature) J. B. Buehler

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) \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature: A. G. King (M. D. or other) M.D.  
Address: 5800 Arsenal Date signed: 2/28/44

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

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**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, fact should be so stated above.**