

FILED OCT 6 1944 18

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. 7002 Registrar's No. 8254

1. PLACE OF DEATH:

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

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

(c) Name of hospital or institution:  
St. Louis City Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17 days  
(Specify whether \_\_\_\_\_)

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

3. (a) PRINT FULL NAME John Wilson

3. (b) If veteran, name war unk. 3. (c) Social Security No. unk.

4. Sex male 0 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Carrie 6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased March 6th. ?  
(Month) (Day) (Year)

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

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Sam Wilson

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

14. Maiden name Hannah Wilson

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 28 44  
(Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director J. W. S. White

(b) Address City Hospital No. 1

19. (a) SEP 27 1944 (Date received local registrar) (b) J. F. Terebeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6411

(c) City or town St. Louis 17 26  
(If outside city or town limits, write "RURAL")

(d) Street No. 1521 No. 9th St.  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29th  
year 1944 hour 4 minute 35 A. M.

21. I hereby certify that I attended the deceased from 8/12/44  
\_\_\_\_\_ 19\_\_\_\_ to Aug. 29th 1944

that I last saw h. im alive on Aug. 29th 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Pyelonephritis non-calculous Duration \_\_\_\_\_

Due to urethral obstruction

Due to urethral strictures & prostatic abscess.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Pyelonephritis; cystitis; CAT; prostatic abscess; urethral stricture

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 0

23. Signature K. R. Schlademan (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Date signed 8/29/44

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.**