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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22757

FILED JUL 27 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6131

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: Barnes Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Glendale (If outside city or town limits, write "RURAL") 11

(d) Street No. 1065 N. Berry Road (If rural, give location) NR 1

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Wilson, Robert Edward

3. (b) If veteran, name war *******

3. (c) Social Security No. ********

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Thursa Wilson

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased April 2 1870 (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 12 If less than one day hr. min.

9. Birthplace Illinois (City, town, or county) 1 (State or foreign country)

10. Usual occupation Physician

11. Industry or business

MOTHER-FATHER

12. Name Johnson Wilson

13. Birthplace Illinois (City, town, or county) 1 (State or foreign country)

14. Maiden name Margaret McKonkey

15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)

16. (a) Informant Thursa Wilson

(b) Address 1065 N. Berry Road Glendale

17. (a) Receiving tomb. (Burial, cremation, or removal) (b) Date thereof July 16 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery.

18. (a) Signature of funeral director Siegenheim Bros

(b) Address 6409 Gravois Ave

19. (a) JUL 16 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14 year 1945 hour 6 minute 45 A.M.

21. I hereby certify that I attended the deceased from July 11, 1945, to July 14, 1945; that I last saw him alive on July 14, 1945, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	3 days
Due to Hypertensive Heart Disease	2 years
Due to	
Other conditions (Include pregnancy within 3 months of death) 93d	

Major findings:
Of operations
Of autopsy Massive hemorrhage in the right hemisphere

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature F. R. Bradley (M. D. or other) 0

Address Barnes Hospital Date signed 7/14/45

(Licensed Embalmer's Statement on Reverse Side)

SEP 18 1945

OCT 22 1945

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.....Homer H. Fritz.....

Licensed Embalmer No.....3882.....

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.