

No. 300
10. 48

FILED FEB 23 1949

STANDARD CERTIFICATE OF DEATH

State File No. 6834
1219

235000
R. 9 17

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

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Overland	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnard Skin & Cancer Hospital		d. STREET ADDRESS (If rural, give location) 3124 Airways Ave.	
3. NAME OF DECEASED a. (First) Leota		c. (Last) Wilson	
4. DATE OF DEATH (Month) (Day) (Year) 2 - 5 - 1949		5. SEX Female	
6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 3-17-1917		9. AGE (In years last birthday) 31	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) East St. Louis, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. Father's Name Clifton Davis		13b. MOTHER'S MAIDEN NAME Ida Palmer	
14. NAME OF HUSBAND OR WIFE James Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME James Wilson, 3124 Airways Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction; Coronary Occlusion, Spinal Anesthesia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) while undergoing an operation for cancer of the mouth at Barnes Hosp on Feb 5 1949 DUE TO (c) at about 9:00 a.m. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 7:59 a.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 174X		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:59 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE Joseph M. Quinn (Degree or title) Deputy		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 2/7/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 2-10-1949		24c. NAME OF CEMETERY OR CREMATORY Father Dickson Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, 2820 Stoddard St.	
DATE REC'D BY LOCAL REG. FEB 9 1949		REGISTRAR'S SIGNATURE J. B. Basata	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Fuller E. Culkin

Licensed Embalmer No. 4198

P. O. Address St. Louis, Mo.

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.