

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43083

BIRTH NO. 84885-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11275

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION SAINT LOUIS MATERNITY		d. STREET ADDRESS (If rural, give location) 27 3206 A LUCAS	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Infant WILSON		4. DATE OF DEATH (Month) (Day) (Year) DEC 12 1949	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, NEVER MARRIED	8. DATE OF BIRTH DEC 12, 1949
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) SAINT LOUIS MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME LEROY JOHN WILSON		13b. MOTHER'S MAIDEN NAME HERTHA LEE FRANKLIN	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME ST. LOUIS MATERNITY HOSPITAL		ADDRESS	
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) Congenital alelectasia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Immature immaturity DUE TO (c) 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 checked="" 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) 194 7625			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 12, 1949, to Dec. 12, 1949, that I last saw the deceased alive on Dec 12, 1949, and that death occurred at 9:30 Am., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl Woodsy, M.D.		23b. ADDRESS	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE DEC 31 1948	
24c. NAME OF CEMETERY OR CREMATORY Annuity Park		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. DEC 31 1949		REGISTRAR'S SIGNATURE J. B. Foster	
FUNERAL DIRECTOR'S SIGNATURE Rowland Service		ADDRESS 4104	

(Licensed Embalmer's Statement on Reverse Side)

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

Beakland 2

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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.