

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20072
State File No.
4981
Registrar's No.

FILED JUN 1 - 1953
BIRTH NO. ... REG. DIST. NO. ... PRIMARY REG. DIST. NO. 1003

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

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 St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital 2209		d. STREET ADDRESS (If rural, give location) 2604 Madison	
3. NAME OF DECEASED (Type or Print) a. (First) Minert b. (Middle) c. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) May 14 1953	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan, 1, 1895
9. AGE (In years last birthday) 58		10. F UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Louisian
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME William Wilson		13b. MOTHER'S MAIDEN NAME Irene Miller	14. NAME OF HUSBAND OR WIFE Annie Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Annie Wilson 2604 Madison
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Anemia	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 2001	
22. I hereby certify that I attended the deceased from 3-16, 1953, to 5-14, 1953, that I last saw the deceased alive on 5-14, 1953, and that death occurred at 7:05a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edna E. Brooks M. D.		23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 5-15-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE May 14 53	24c. NAME OF CEMETERY OR CREMATORY Oak Dale	24d. LOCATION (City, town, or county) (State) Le May Mo
DATE REC'D BY LOCAL REG. MAY 18 1953	REGISTRAR'S SIGNATURE J. C. Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS J. J. Stinson 2749 Chester	

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. 2495

P. O. Address 2769 Chautau

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.