

FILED NOV 24 1953

STANDARD CERTIFICATE OF DEATH

State File No. **41405**
Registrar's No. **10570**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 18 1215 S. Compton	
3. NAME OF DECEASED (Type or Print) a. (First) Sam b. (Middle) c. (Last) Wilson		4. DATE OF DEATH (Month) 11 (Day) 6 (Year) 53	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 29-1890
9. AGE (In years last b'day) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	11. BIRTHPLACE (City and State or Foreign Country) St. Louis MO
10b. KIND OF BUSINESS OR INDUSTRY City		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Sam B Wilson		13b. MOTHER'S MAIDEN NAME Alice	
14. NAME OF HUSBAND OR WIFE Sarah Wilson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Sarah Wilson 1215 S. Compton	

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Carcinoma Emphysema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Undt.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Metastasis to Liver				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X

22. I hereby certify that I attended the deceased from 11-1, 1953, to 11-6, 1953, that I last saw the deceased alive on 11-6, 1953, and that death occurred at 4:35 A.m., from the causes and on the date stated above.

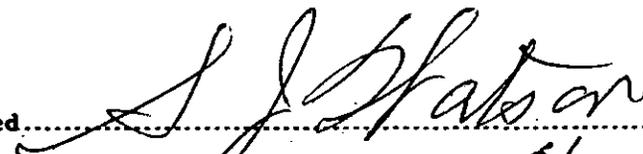
23a. SIGNATURE (Degree or title) E. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 11-6-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov 9-53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis Mo
DATE REC'D BY LOCAL REG. NOV 7 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. J. Watson 2769 Chouteau	

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

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.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No. 269

P. O. Address 2769

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.