

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10540**
Registrar's No. **2701**

FILED APR 2 1954

REG. DIST. NO. **318** 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)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY OR TOWN Waynesville	b. COUNTY Pulaski
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)
a. (First) Roy	b. (Middle) Clifton	c. (Last) Wilson	Mar. 23 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 13, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) (Months) (Days) (If under 1 year) 55
11. BIRTHPLACE (City and State or Foreign Country) Waynesville, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Wilson		13b. MOTHER'S MAIDEN NAME Mary Tipton	14. NAME OF HUSBAND OR WIFE Josie Wilson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME Josie Wilson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		ADDRESS Waynesville, Missouri.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
*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 POST Operative Glioblastoma Multiforme	
ANTECEDENT CAUSES		DUE TO (b)	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 3-22-54	19b. MAJOR FINDINGS OF OPERATION Glioblastoma Multiforme		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) 193X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 Mar. 12, 1954 to Mar. 23, 1954 , that I last saw the deceased alive on Mar. 23, 1954 , and that death occurred at 3:20P m. , from the causes and on the date stated above.			
23a. SIGNATURE G. J. Vermillion, M.D.		23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED
24a. BURIAL / CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-24-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Waynesville, Missouri.
DATE REC'D BY LOCAL REG. MAR 24 1954	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	

1955 JUL 8 70P

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 *J. Wm Dumbley*.....

Licensed Embalmer No. *3653*.....

P. O. Address *St. Louis 8*.....

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.