

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24445

FILED AUG 2 - 1954

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6680**

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY OR TOWN St. Louis, Mo. c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ 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"/> e. STREET ADDRESS (If rural, give location) 1118 So. Ewing 222/0	
3. NAME OF DECEASED (Type or Print) Wilbur a. (First) _____ b. (Middle) _____ c. (Last) Dees		4. DATE OF DEATH (Month) (Day) (Year) 7-15-54	
5. SEX Male 6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 4-10-53		9. AGE (In years last birthday) 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Walter Dees		13b. MOTHER'S MAIDEN NAME Rose Muriel Smith	
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 J. Johnston	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Malformation of brain ANTECEDENT CAUSE Baroness base DUE TO (b) 7-15-54 DUE TO (c) Released 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 Mr. Jas. H. ...	
20. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
22. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		23. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
24. HOW DID INJURY OCCUR? 7531		25. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) W3 Deputy Gov	
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 _____, 19____, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Wm. H. Klingberg MD		23b. ADDRESS Childrens Hospital	
23c. DATE SIGNED 7-19-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	
24b. DATE July 20, 54		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem. St. Louis	
24d. LOCATION (City, town, or county) (State) Mo.		25. FUNERAL DIRECTOR'S SIGNATURE F. A. Green	
DATE REC'D BY LOCAL REG. JUL 20 1954		26. ADDRESS 4214 Delmar	

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 *F. A. Green*.....

Licensed Embalmer No. *296*.....

P. O. Address *4214 Colma*.....

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.