

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25445

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7176**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis MO		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		2259
d. FULL NAME OF HOSPITAL OR INSTITUTION HOMER G PHILLIPS			d. STREET ADDRESS (If rural, give location) 25 1124N 15th ST		
3. NAME OF DECEASED (Type or Print) JOSEPH		a. (First)	b. (Middle)	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) 7 30 54
5. SEX MALE	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 5-27-52	9. AGE (In years last birthday) 2
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?

13a. FATHER'S NAME ALLEN BAKER		13b. MOTHER'S MAIDEN NAME LOIS WILSON		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS LOIS WILSON 1124N 15th ST.	

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) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchialitis DUE TO (c) Diarrhea, acidosis, clinical II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND 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)	
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? 260X	

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 **425 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree of title) Samuel E. ...		23b. ADDRESS 21300 Clowse		23c. DATE SIGNED 8/2/54	
24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL		24b. DATE 8-4-54		24c. NAME OF CEMETERY OR CREMATORY OAKDALE	
24d. LOCATION (City, town, or county) (State) ST LOUIS CO. MO					

DATE REC'D BY LOCAL REG. AUG 2 1954		REGISTRAR'S SIGNATURE Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennie Love 3103 Washington	
---	--	---	--	--	--

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
Student Embalmer

Signed W. Clavelle Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.