

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

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STATE FILE NUMBER 7216

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If NOT in hospital, give location) ST. LOUIS CITY HOSPITAL #1		Length of stay in lb	22. STREET ADDRESS 2808 RUTGAR ST.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last URSIE WILBURN			4. DATE OF DEATH Month Day Year AUGUST 1, 1956		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 1 1887	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAB.		10b. KIND OF BUSINESS OR INDUSTRY UNK.	11. BIRTHPLACE (City and state or country) STONE MT. GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME P.J. WILBURN			14. MOTHER'S MAIDEN NAME ANNA WILBURN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO NO		16. SOCIAL SECURITY NO. UNK.	17. INFORMANT Address JAMES WILBURN 4734 LABADIE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 332x				
20c. TIME OF INJURY Hour, Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 7/2/56 to 8/1/56 and last saw her alive on 8/1/56 Death occurred at 9:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22. SIGNATURE (Degree or title) Carson M. Bernstein MD			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 8/2/56.
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 8-6-56	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		23d. LOCATION (City, town, or county) (State) ST LOUIS, COUNTY	
24. FUNERAL DIRECTOR ADDRESS J. MC CLENDON 4535 WASHINGTON		25. DATE RECD. BY LOCAL REG. AUG 4 1956	26. REGISTRAR'S SIGNATURE Earl Smith md		

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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. 44

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.