

FILED FEB 4 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47679

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12459

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Vinite Terrace</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb <u>22 days</u>	d. STREET ADDRESS (If outside, give location) <u>8025 Monroe St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETTYE MAE WILSON</u>			4. DATE OF DEATH Month Day Year <u>DECEMBER 24, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 14, 1923</u>		9. AGE (In years last birthday) <u>34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Erwin L. Kahle</u>		13b. MOTHER'S MAIDEN NAME <u>Sadie Berndt</u>		14. NAME OF HUSBAND OR WIFE <u>Donald I. Wilson</u>	
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. <u>Unknown</u>	17. INFORMANT <u>Donald I. Wilson</u>		Address <u>St. Louis, Mo. 8025 Monroe St. Vinite Terrace</u>
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>SUBARACHNOID HEMORRHAGE, TEMPORAL AREA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>IRRADIATION THERAPY</u>					6 MONTHS
DUE TO (c) <u>MONOCYTTIC LEUKEMIA</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>GRANULOMATOUS INFECTION OF LUNG</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 <u>DEC. 2, 1957</u> to <u>DEC. 24, 1957</u> and last saw her/him alive on <u>DEC. 24, 1957</u> Death occurred at <u>12:05 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. C. Vermillion, M.D.</u> (Degree or title)			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>12/24/57</u>
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>12/27/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Collinsville, Ill.</u>
24. FUNERAL DIRECTOR <u>Schroepel Funeral Home,</u>		ADDRESS <u>Collinsville Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 26 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Paul E. Froman*

Licensed Embalmer No. *7908*

P. O. Address *Collinsville, Mo.*

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.