Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012504
STATE FILE NUMBER

FILED APR 9 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3115

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mo. Baptist Hospital — Length of stay in Hospital 88 yrs	d. STREET ADDRESS (If outside, give location) 2912 Geyer Avenue — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle E.	Last WILSON	4. DATE OF DEATH	Month Day Year Mar. 16, 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH Sept.21,1869	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) distribution dept.	10b. KIND OF BUSINESS OR INDUSTRY newspaper	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William H. Wilson	13b. MOTHER'S MAIDEN NAME Elizabeth Eastwood	14. NAME OF HUSBAND OR WIFE Marianna Thompson Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 492-20-1969	17. INFORMANT Kennett T. Wilson 2912 Geyer Avenue			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chr pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH 3 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Duodenal ulcer 600.0

19. WAS AUTOPSY PERFORMED? YES [✓] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 april 7, 1958 to march 16, 1958 and last saw her/him alive on march 16, 1958

Death occurred at 9:50 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Stanley M. Reid (Degree or title) MD

22b. ADDRESS 457 N. Kingshighway

22c. DATE SIGNED 3/17/58

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE Mar.19,1958

23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery

23d. LOCATION (City, town, or county) St. Louis, Missouri (State)

24. FUNERAL DIRECTOR BEIDERWIEDEN F.H.INC.,1936 St.Louis Av

ADDRESS

25. DATE RECD. BY LOCAL REG. MAR 18 58

26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr. Stanley M. Wald
457 N. Kingshighway

1-5 P.M.

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 [signature]

Licensed Embalmer No. 4520

P. O. Address St. Louis

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.