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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034842  
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9007

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-57  
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|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>   |   | Length of stay in lb<br><b>40 Years</b>   | d. STREET ADDRESS (If outside, give location)<br><b>5924 Pershing Ave</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                         |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Ruth Margaret Wilson</b>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Sept. 16, 1958</b>   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 4, 1892</b>   |  | 9. AGE (In years Last birthday) <b>66</b><br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None (Semi-Invalid)</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Randolph Co, Illinois</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>JAMES MARTIN WILSON</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>EMMA JANE FORSYTHE</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>                                     |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mr Hugh S. Wilson 5924 Pershing Ave</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic Pneumonia</b><br>DUE TO (b) <b>Fracture of the right Hip</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Suffered in fall in room at Jewish Hospital on August 11th 1958.</b> |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED (e.g., nature of injury in PART I or PART II of item 18.)<br><b>at Jewish Hospital on August 11th 1958.</b> |   |   |  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br><b>8 11 58</b>  |   | 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.)<br><b>17th Floor</b>   |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br><b>St. Louis Mo</b>  |   |  |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at <b>355 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |   |   |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>James M. Kelly Esq. Deputy</b>   |   |   | 22b. ADDRESS<br><b>1300 Clark</b>   |  | 22c. DATE SIGNED<br><b>9-18-58</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>9/18/58</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Cemetery</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co, Missouri</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Alexander &amp; Sons 6175 Delmar Bl</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 18 '58</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith</b>   |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

NO E904.7 45

Handwritten signature and initials

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 *jos. E. McCulloh*  
Licensed Embalmer No. *2464*  
P. O. Address *6175 Elm*

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.