

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015978

STATE FILE NUMBER

2 3439

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. may use any standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mississippi b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Houlika
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Louis Little Rock Hosp Inc		Length of stay in lb 10 days	d. STREET ADDRESS (If outside, give location) P.O. Box 413
3. NAME OF DECEASED (Type or print) First Middle Last Son Wilson			4. DATE OF DEATH Month Day Year April 5, 1959
5. SEX Male 2	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 10, 1920
9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Laborer	11. BIRTHPLACE (City and state or country) Houlika, Miss.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Fate Wilson	13b. MOTHER'S MAIDEN NAME Mollie Forshe
14. NAME OF HUSBAND OR WIFE Earline Wilson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 428,16,3217
17. INFORMANT Mrs. Earline Wilson Houlika, Mississippi		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate c DUE TO (b) Metastasis to bone & Lungs. DUE TO (c) 177X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia	
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.)		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 March 27, 1959 to April 5, 1959 and last saw him alive on April 5, 1959 Death occurred at 8:45 am on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Charles Frouner, M.D.</i> (Degree or title)		22b. ADDRESS 1755 So. Grand Blvd	22c. DATE SIGNED 4/6/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/7/59	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) New Albany, Mississippi
24. FUNERAL DIRECTOR G. Wade Granberry 4202 Finney Ave.		25. DATE RECD. BY LOCAL REG. APR 7 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

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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 *Edward H. Flynn*

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

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.