

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. MAY 13 1960

-60-017478

2 4389

STATE FILE NUMBER

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		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D. O. A. Homer Phillips		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4222nd Cote-Brillante
3. NAME OF DECEASED (Type or print) BENJAMIN FRANKLIN WILSON		First Middle Last	4. DATE OF DEATH Month Day Year 4 - 23 - 60
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-13-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Day Hours Min. 4 9
11. BIRTHPLACE (City and state or country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME BENJAMIN F. WILSON		13b. MOTHER'S MAIDEN NAME FANNIE E. SCHOEBE	
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. -	
17. INFORMANT F. Z. WILSON		Address 4222nd Cote-Brillante	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gaugestion and Edema of Lung DUE TO (b) Constrictive Heart Failure DUE TO (c) 434-1		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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 a.m. p.m.	Month, Day, Year	
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 **1235 P** to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE Joseph M. Gordon (Degree or title)	21b. ADDRESS 1300 Elder	21c. DATE SIGNED 4-24-60
22a. BURIAL, CREATION, REMOVAL (Specify) REMOVAL	22b. DATE 4-24-60	22c. NAME OF CEMETERY OR CREMATORY GARY, INDIANA
23. FUNERAL DIRECTOR Gordon-English	ADDRESS 1123 N. Taylor	24. DATE RECD. BY LOCAL REG. APR 24 1960
25. REGISTRAR'S SIGNATURE Earl Smith M.D.		

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 1123 N. 7

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