

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-040457**

FILED VS NOV 9 1960

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3075

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>ST. LOUIS</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b>		Length of stay in 1b <b>YRS</b>		c. CITY OR TOWN <b>WEBSTER GROVES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>614 ELBART</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>614 ELBART</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ROSS</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>OCT.</b> Day <b>22</b> Year <b>1960</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/21/1897</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PURCHASER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE MFG.</b>		11. BIRTHPLACE (City and state or country) <b>KEOKUK, IOWA</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM COLLIER WILSON</b>			13b. MOTHER'S MAIDEN NAME <b>MARY ROSS</b>			14. NAME OF HUSBAND OR WIFE <b>LOUISE MENKE WILSON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES WW I</b>			16. SOCIAL SECURITY NO. <b>489-01-1847</b>		17. INFORMANT Address <b>MRS. W. B. WILSON, 614 ELBART GROVES, MO</b>			WEBSTER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arteriosclerosis</b>							1 yr.	
DUE TO (c)								
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 <b>1955</b> to <b>Oct. 22, 1960</b> and last saw him alive on <b>Oct. 22, 1960</b>				Death occurred at <b>5:50 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				
22. SIGNATURE (Degree of title) <b>James W. Walsh, M.D.</b>				22b. ADDRESS <b>3720 Washington (8)</b>		22c. DATE SIGNED <b>10-24-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>OCT. 25, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		23d. LOCATION (City, town, or county) <b>KIRKWOOD, MO.</b>			(State)	
24. FUNERAL DIRECTOR ADDRESS <b>PARKER*ALDRICH, WEBSTER GROVES, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>10-24-60</b>		26. REGISTRAR'S SIGNATURE <b>John B. Mumfry M.D.</b>		

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W E Morris

Licensed Embalmer No. 336

P. O. Address St Louis

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