

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

2520

-61-011792

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

AMENDED

FILED MAR 20 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>		c. CITY OR TOWN <b>East St. Louis</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>623a No. 14th</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>Terri May Wilson</b>			<b>March 14, 1961</b>		

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-61</b>	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (City and state or country)	Months	Days	Hours
			<b>St. Louis, Mo</b>		<b>2</b>	<b>14</b>

10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME <b>William Albert Wilson</b>	13b. MOTHER'S MAIDEN NAME <b>Wilma Kay Walker</b>	14. NAME OF HUSBAND OR WIFE
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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. <b>None</b>	17. INFORMANT <b>Wilma K. Wilson</b>	Address <b>623a No. 14th E. St. Louis, Ill</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Respiratory Center Failure</b>	<b>12 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Edema</b>	<b>12 hours</b>
	DUE TO (c) <b>Prematurity 760.5</b>	<b>2 days</b>
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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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
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21. I attended the deceased from **3-12-61** to **3-14-61** and last saw <sup>her</sup> <sub>him</sub> alive on **3-14-61**.  
Death occurred at **10:15 P.M.** **3-14-61** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>William H. Davis M.D.</b>	22b. ADDRESS <b>3121 N. Grand</b>	22c. DATE SIGNED <b>3-15-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Mar. 15, 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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24. FUNERAL DIRECTOR <b>McLaughlin</b>	ADDRESS <b>2301 Lafayette</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 16 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

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

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

Signed A. G. Farrin

Licensed Embalmer No. 3384

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.