

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-031222
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8001

AMENDED

FILED SEP 6 1961 318

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>8 yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hosp. #2,</u>		d. STREET ADDRESS (If outside, give location) <u>5200 Von Phul</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN LOUIS WILKERSON</u>			4. DATE OF DEATH Month Day Year <u>August 25, 1961</u>	
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-1953</u>	9. AGE (last birthday) <u>8 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Wilkerson</u>	13b. MOTHER'S MAIDEN NAME <u>LaVerne Donohue</u>	14. NAME OF HUSBAND OR WIFE <u>Never married</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. LaVerne Wilkerson, 5200 Von Phul</u>
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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: <u>HEMORRHAGE FROM RIGHT RENAL VEIN; MULTIPLE SKULL FRACTURES WITH SUBDURAL HEMORRHAGE; CONCUSSION SUFFERED WHEN STRUCK BY CAR OPERATOR BY ONE ALAN BLOZ ON MARK TWAIN HIGHWAY ABOUT 9:25 PM ON AUGUST 24, 1961</u>		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>FRAGTURES WITH SUBDURAL HEMORRHAGE; CONCUSSION</u>		
DUE TO (b) <u>TWAIN HIGHWAY ABOUT 9:25 PM ON AUGUST 24, 1961</u>	Accident	

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>(SEE ABOVE)</u>
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20c. TIME OF INJURY <u>9:25 p.m.</u>	Month, Day, Year <u>8-24-61</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>91 Highway</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY <u>Missouri</u>	STATE
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21. I attended the deceased from _____, to _____ and last saw him alive on _____.
Death occurred at 12:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <u>Paul J. Simon Deputy Coroner</u>	22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>8/28/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-29-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>Stock Mortuaries, 2117 E. Grand Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 28 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Paul A. Wachter

Licensed Embalmer No. 47183
P. O. Address Shawano

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.