

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039275

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 162 Primary Registration District No. 5595 Registrar's No. 126

FILED OCT 22 1962

VS 300
Rev. 4/59

10500
28480

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4 0
5 2
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7 1
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9332X
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1286-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wisconsin b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) Rock		c. CITY OR TOWN Milwaukee	
Length of stay in 1b		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Four Oaks Home		d. STREET ADDRESS (If outside, give location) 171 W. Van Norman St.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM LOY WILSON			4. DATE OF DEATH Month Day Year OCT. 15 1962
5. SEX M.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1877
9. AGE (last birthday) 84		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY General Merchandise	11. BIRTHPLACE (City and state or country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY U. S. A		13a. FATHER'S NAME Frank C. Wilson	
13b. MOTHER'S MAIDEN NAME Ariminta M. Gillam		14. NAME OF HUSBAND OR WIFE Maude Mulroy DEceased	
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 Mrs. Henry Sukowski		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Middle Cerebral artery thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral artery sclerosis			5 yrs
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 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 10/13/62 to 10/15/62 and last saw him alive on 10/15/62 Death occurred at 2 P m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles Burnside MD		22b. ADDRESS 206 W. Argonne Road Milwaukee, Wis.	22c. DATE SIGNED 10/15/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Oct 15, 62	23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Cem.	23d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin
24. FUNERAL DIRECTOR Heiligttag--Imperial, Mo.		25. DATE RECD. BY LOCAL REG. 10-15-62	26. REGISTRAR'S SIGNATURE Robert E Bauer

USE BLACK INK OR TYPEWRITER RIBBON

OCT 25 1962

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 Elmer Halitag

Licensed Embalmer No. 3571

P. O. Address Imperial mo

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.