

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004322
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 790

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JAN 31 1963						
1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Length of stay in 1b c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 4475 Forest Park Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First FLOYD Middle CURTIS Last WILSON	4. DATE OF DEATH Month 1 Day 20 Year 63					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1915	9. AGE (last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) Datto, Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.			
13a. FATHER'S NAME Gus Wilson	13b. MOTHER'S MAIDEN NAME Stella Jackson	14. NAME OF HUSBAND OR WIFE Vada Wilson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. NO.		17. INFORMANT Address Mrs. Vada Wilson, 4475 Forest Park		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Membranous Glomerulonephritis					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 593x						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Curious of Lower. nutritional					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)				
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 11 - 19 - 62 to 1 - 20 - 63 and last saw her/him alive on 1 - 20 - 63 Death occurred at 6:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Thomas J. Ridzon M.D.</i>		(Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 1/21/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-24-63	23c. NAME OF CEMETERY OR CREMATORY Richwood Cemetery	23d. LOCATION (City, town, or county) (State) Corning, Ark.			
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. JAN 24 1963	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>				

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RIDDZON
USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59
1
2 **2/9**
3
4 **0**
5 **1**
6
7 **1**
8 **1**
9
10
11
12 **75-0**
13

STATE BOARD OF HEALTH
MISSOURI

10-1-11

STATEMENT BY LICENSED EMBALMER

10-29

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 Elton R. Penelvis

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.