

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30544

FILED AUG 20 1953

7234

BIRTH NO. 48370 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Ill. b. COUNTY St. Clair			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN East St. Louis		8/20	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital				d. STREET ADDRESS (If rural, give location) 1037 Trendley			
3. NAME OF DECEASED (Type or Print) a. (First) Lorene			b. (Middle) Willis		c. (Last) Willis		
4. DATE OF DEATH (Month) (Day) (Year) 7 23 53		5. SEX Female-3		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	
8. DATE OF BIRTH 7 - 20 - 53		9. AGE (In years last birthday) 0 0		IF UNDER 1 YEAR Months Days 0 2		IF UNDER 24 HRS. Hours Min. 3 26	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Chester Willis		13b. MOTHER'S MAIDEN NAME Magnolia Townsend		14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Chester Willis		ADDRESS 1037 Trendley	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES DUE TO (b) atelectasis of the lungs Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) aspiration of foreign material II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 7-6-10			
22. I hereby certify that I attended the deceased from 7-21, 1953, to 7-23, 1953, that I last saw the deceased alive on 7-23, 1953, and that death occurred at 2:00 A.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) William L. Kumpmann M.D.				23b. ADDRESS Desloge Hosp. St. Louis Mo		23c. DATE SIGNED 7-23-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-25-53		24c. NAME OF CEMETERY OR CREMATORY Booker Washington		24d. LOCATION (City, town, or county) (State) East St. Louis, Illinois	
DATE REC'D BY LOCAL REG. JUL 25 1953		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE C. J. Nash		ADDRESS 111 N. 13th	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed C. J. Nash

Licensed Embalmer No. 2732

P. O. Address 3847 Page

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 this body is not embalmed, fact should be so stated above.