

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32329

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8072

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO c. LENGTH OF STAY (in this place) _____

c. CITY OR TOWN ST. LOUIS d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION DE PAUL HOSPITAL

e. STREET ADDRESS (If rural, give location) 23 2637 OREGON

3. NAME OF DECEASED a. (First) LEWIS b. (Middle) WILLHELMY c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year) AUG. 31 1954

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED

8. DATE OF BIRTH MAR 13 1906

9. AGE (In years last birthday) 48 IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER

10b. KIND OF BUSINESS OR INDUSTRY REXALL DRUG

11. BIRTHPLACE (City and State or Foreign Country) WISCONSIN

12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME LEVI WILLHELMY

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE ARMELLA WILLHELMY

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. 491-16-6808

17. INFORMANT'S SIGNATURE OR NAME ADDRESS ARMELLA WILLHELMY 2637 OREGON

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesentery Thrombosis
ANTECEDENT CAUSES Cirrhosis of liver
Morbidity conditions, if any, giving rise to the above cause (c) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 10 days
2 yrs

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 5810

22. I hereby certify that I attended the deceased from 8-23, 1954, to 8-30, 1954, that I last saw the deceased alive on 8-30, 1954, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. F. Lerner MD

23b. ADDRESS 1259 N. Kingshighway

23c. DATE SIGNED 9-1-54

24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL

24b. DATE SEPT 3 1954

24c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEM.

24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REG. SEP 1 1954

REGISTRAR'S SIGNATURE Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kulla 2906 Grand

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

207-5340
1-3-74
P.M.

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 *Samuel C Hill*.....

Licensed Embalmer No. *4347*.....

P. O. Address *2906*.....

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.