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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 - 1955

31613

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8447**

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 St Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Barnes Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 5750 Vernon avenue		(If rural, give location) 20570	

3. NAME OF DECEASED (Type or Print) William Vester			4. DATE OF DEATH 9-25-55		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 12-8-1903		9. AGE (In years last birthday) 51		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) grinder		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (City and State or Foreign Country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME George Vester		13b. MOTHER'S MAIDEN NAME Dora Harrison		14. NAME OF HUSBAND OR WIFE Mary Vester	
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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) no		16. SOCIAL SECURITY NO. 429-36-4703		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bill Robertson, 4957a Arsenal st.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Oedema		ANTECEDENT CAUSES			
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Cardiac Hypertrophy			
		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 434.3		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **1100A** m., from the causes and on the date stated above.

23a. SIGNATURE Patrick P. Taylor Coroner		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 9-26-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9-26-55		24c. NAME OF CEMETERY OR CREMATORY Corning, Ark.	
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DATE REC'D BY LOCAL REG. SEP 26 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell-Ermert, Corning, Ark.	
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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

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 *Louis C. Branson*.....

Licensed Embalmer No. *47*.....

P. O. Address *St. Louis*.....

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.