

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36397**
Registrar's No. **9839**

FILED NOV 16 1956

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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) ST. LOUIS		c. LENGTH OF STAY (in this place) 4 months		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 4116 Carter (West)			
3. NAME OF DECEASED a. (First) LILLIAN		b. (Middle)		c. (Last) Willard	
4. DATE OF DEATH 10-26-56		5. SEX Female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 9-4-86		9. AGE (In years last birthday) 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY unemployed		11. BIRTHPLACE (City and State or Foreign Country) Illinois (Raibs Station)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME THOMAS DAVIS		13b. MOTHER'S MAIDEN NAME Emma (Davis)	
14. NAME OF HUSBAND OR WIFE Mr. Willard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 486-28-2509	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Alice Pottemann		17. ADDRESS 4116 West 84th St Hospital Records of St. Louis Chronic		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Arteriosclerosis	
19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 7	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 334X	
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?	
22. I hereby certify that I attended the deceased from 6-19 , 19 56 to 10-26 , 19 56 , that I last saw the deceased alive on 10-26 , 19 56 , and that death occurred at 7:35 pm. , from the causes and on the date stated above.					
23a. SIGNATURE John Niederwieser		23b. ADDRESS M.D. 5600 Arsenal, St. Louis		23c. DATE SIGNED 10-27-56	
24. BURIAL, CREMATION, REMOVAL (Specify) Removal via Motor		24b. DATE 10-29-56		24c. NAME OF CEMETERY OR CREMATORY Walnut Hill Cemetery	
24d. LOCATION (City, town, or county) (State) Belleville Illinois		25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc.		25. ADDRESS 2161 E. Fair Ave	
DATE REC'D BY LOCAL REG. OCT 29 1956		REGISTRAR'S SIGNATURE Carl Smith MD		(Licensed Embalmer's Statement on Reverse Side)	

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.....
Licensed Embalmer No. 420
P. O. Address.....

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.