

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30184

State File No. 7479

FILED AUG-26 1957

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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) 3 Yrs. 11		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hospital				e. STREET ADDRESS (If rural, give location) 37 5800 Arsenal St.			
3. NAME OF DECEASED (Type or Print) a. (First) Nellie b. (Middle) _____ c. (Last) Wills			4. DATE OF DEATH (Month) (Day) (Year) August 9-1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH January 1, 1869	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months 7 Days 8	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Cairo, Ill.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Thomas Martin		13b. MOTHER'S MAIDEN NAME Nellie Bankston		14. NAME OF HUSBAND OR WIFE Jeff Wills.			
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Cleo Sanders 711 Dallas Dr. Lemay 23 Mo.			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES *forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Thrombosis Arteriosclerotic Coronary DUE TO (c) Generalized Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Cystitis (nonspecific) Multiple Deaciditi				INTERVAL BETWEEN ONSET AND DEATH Old Man 4 yrs. 4 yrs. 4 yrs 2 mo.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 420.1		20. AUTOPSY? 2 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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Aug. 13, 1957 to Aug. 9, 1957 , that I last saw the deceased alive on Aug. 9, 1957 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John W. Beckham, M.D.				23b. ADDRESS 5800 Arsenal		23c. DATE SIGNED 8/10/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/12/57	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL _____		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.			

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 *John E. Percy*.....
Licensed Embalmer No. *409*.....
P. O. Address *St. Louis, Mo.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If
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.