

Health,
Welfare
Public
Service

300
1-56

3
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34310
STATE FILE NUMBER
8953
Registration District No. 318 Primary Registration District No. 1003

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		Length of stay in 1b D.O.A.		STREET ADDRESS 5772 W. Florissant Ave		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William J Westergaard				4. DATE OF DEATH Sept 21 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1887	
9. AGE (In years last birthday) 69		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (City and state or country) Copenhagen, Denmark	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andraers Westergaard				14. MOTHER'S MAIDEN NAME Wilhelmina Nielson	
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. 98-05-6033		17. INFORMANT Address Mrs. Victor Lieber, 4131a Clay Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suffocation by hanging</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>E974X</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>While falling and impaled self in O'Fallon Park on</i>					
20c. TIME OF INJURY Hour Month, Day, Year a. m. 9 21 p. m. September 21, 1957.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Park</i>		20f. CITY, TOWN, OR LOCATION St Louis Mo	
21. I attended the deceased from <i>1008 A</i> to _____ and last saw ^{her} _{him} alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Joseph M. Quinn</i> (Degree) <i>Deputy</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>9/25/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Sept 26 1957		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair A				25. DATE RECD. BY LOCAL REG. SEP 25 57		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, m.d.</i> S.P.	

(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 *Clement M. Neary*

Licensed Embalmer No. *37*

P. O. Address *A. L. ...*

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.