

Health,  
& Welfare  
Public  
Service

S. 300  
v. 1-57

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42783  
STATE FILE NUMBER  
Registrar's No. 10993

FILED NOV 25 1957

Registration District No. 318 Primary Registration District No. 1003

|   |                        |  |   |   |   |
|---|------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY   |   |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN St. Louis   |                        | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | c. CITY OR TOWN St. Louis   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION 8220 No. Broadway  |                        | Length of stay in lb 1 year  |   | d. STREET ADDRESS 8220 No. Broadway                               |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First MIDDLE Last<br>LUDWIG G WILL  |                        |  | 4. DATE OF DEATH<br>Month Day Year<br>Nov 16 1957                   |   |   |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>October 27, 1878                                | 9. AGE (In years last birthday) 79                                | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min.                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired-Draftsman  |                        | 10b. KIND OF BUSINESS OR INDUSTRY<br>No. St. Louis Car Co.   |   | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13a. FATHER'S NAME<br>John Will   |                        | 13b. MOTHER'S MAIDEN NAME<br>Ernestine Kalp  |   | 14. NAME OF HUSBAND OR WIFE<br>Deceased                           |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, No, or unknown) (If yes, give war or dates of service)<br>No.   |                        | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address<br>Mr. Ernst Schroeder 822 Wall Street   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>art sclerotic cardio vas dis.</i>  |                        |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 1/2 yrs.</i>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____<br>DUE TO (c) _____   |                        |  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>422.1</i>   |                        |  |   |   | 19. WAS AUTOPSY PERFORMED? 2<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.  |                        |  |   |   |   |
| 20d. INJURY OCCURRED WHILE AT <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.)   |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                         |   |
| 21. I attended the deceased from <i>5-7-56</i> to <i>11-16-57</i> and last saw <sup>her</sup> him alive on <i>10-16-57</i><br>Death occurred at <i>6:00 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated. |                        |  |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><i>Wayne O. Berghman</i>  |                        |  | 22b. ADDRESS<br><i>100 No Euclid</i>                                |   | 22c. DATE SIGNED<br><i>11-16-57</i>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Removal</i>   |                        | 23b. DATE<br><i>Nov. 18, 1957</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Bethlehem Cemetery</i> |   | 23d. LOCATION (City, town, or county), (State)<br><i>St. Louis County, Missouri</i>                 |
| 24. FUNERAL DIRECTOR<br><i>Math Hermann &amp; Son, Inc.,</i> ADDRESS<br><i>2161 E. Fair</i>   |                        | 25. DATE RECD. BY LOCAL REG.<br><i>NOV 18 57</i>   |   | 26. REGISTRAR'S SIGNATURE<br><i>Carl Smith MD</i>                 |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

*-m 8 B*

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. Gears* .....

Licensed Embalmer No. *3732* .....

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.