

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023230

STATE FIVE NUMBER

5124

FILED JUN 16 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

5. 300

1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Midlink 4250</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>JEWISH HOSPITAL</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>27 2754 Brouster</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM OMULOUS DANIELS</u>			4. DATE OF DEATH Month Day Year <u>May 13 1958</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4-1901</u>
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Roller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Piedmont, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. NAME OF HUSBAND OR WIFE <u>Mattie Daniels</u>	
13a. FATHER'S NAME <u>John William Daniels</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie May Hampton</u>	
14. NAME OF DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		15. SOCIAL SECURITY NO. <u>585-10-6658</u>	
16. INFORMANT Address <u>Mrs. Mattie Daniels -2754 Brouster</u>		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ACUTE MYELOCYTIC LEUKEMIA</u> DUE TO (c) <u>204.3</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CORONARY INSUFFICIENCY</u>			INTERVAL BETWEEN ONSET AND DEATH
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 Hour Month, Day, Year a.m. 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 <u>5/11/58</u> to <u>5/19/58</u> and last saw her/him alive on <u>5/19/58</u> Death occurred at <u>7:00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arden Cohn M.D.</u>		22b. ADDRESS <u>JEWISH HOSP. ST. LOUIS</u>	
22c. DATE SIGNED <u>5/15/58</u>		22d. PLACE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 16-1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Piedmont, Mo.</u>	
24. FUNERAL DIRECTOR <u>Earl Hilleman</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 15 '58</u>	
26. REGISTERAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>		26. REGISTERAR'S SIGNATURE <u>S.P.</u>	

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 *E. F. Hillman*

Licensed Embalmer No. *3501*

P. O. Address *Ovesland 14 7/2*

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.