

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002850

STATE FILE NUMBER
2 703

FILED FEB 10 1959

Registration District No. _____ Primary Registration District No. _____

Registrar's No. _____

300
-57

25
34

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</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>Affton</u> <u>4600</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Johns Hosp.</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>8827 Rock Forest</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle _____ Last <u>Daut</u>	4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1959</u>
---	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1876</u>	9. AGE (In years and birthday) <u>82</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>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	--	--

13a. FATHER'S NAME <u>William Williamson Sr.</u>	13b. MOTHER'S MAIDEN NAME <u>Catherinè Ittner</u>	14. NAME OF HUSBAND OR WIFE <u>Fred L.</u>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Norman Daut--8827 Rock Forest</u> Address _____
---	--	--

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>Thrombosis of rt. vent. striate art.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertensive arteriosclerosis vasculocardio</u> DUE TO (c) <u>auricular fibrillation</u> <u>443X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <u>NO NO NO</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--

21. I attended the deceased from <u>Jan 15-59</u> to <u>Jan 20-59</u> and last saw her/him alive on <u>Jan 19-59</u> Death occurred at <u>2:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John J. Hammond M.D.</u> (Degree or title)	22b. ADDRESS <u>634 N. Grand</u>	22c. DATE SIGNED <u>1/20/59</u>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/23/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>WACKER-HELDERIE</u> ADDRESS <u>3634 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 21 59</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.
--	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Selvig J. Krupin*
Licensed Embalmer No. *3497*
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.