

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011522

STATE FILE NUMBER

2, 2295

FILED MAR 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

300
1-57
94
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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>7</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>St. Louis</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>5228 Lexington</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>5228 Lexington</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>EDMOND WILLIS, SR.</u>			4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1959</u>			
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5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negro</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>Dec. 25, 1904</u>	9. AGE (In years last birthday) <u>54</u>	10. FUNDER 1 YEAR Months <u>2</u> Days <u>8</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sky Cap</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lambert Air Port</u>	11. BIRTHPLACE (City and state or country) <u>Bolivar, Tenn.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>George Willis</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Coates</u>	14. NAME OF HUSBAND OR WIFE <u>Annabelle Willis</u>
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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>488-05-7491</u>	17. INFORMANT <u>Annabelle Willis</u> Address <u>5228 Lexington</u>
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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>CARCINOMA RT. KIDNEY - METASTATIC</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	<u>180x</u>
	DUE TO (c) _____	
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"/> <u>2</u>

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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from <u>Feb 8, 1958</u> to <u>March 3, 1959</u> and last saw ^{her} _{him} alive on <u>March 2, 1959</u> Death occurred at <u>1:55</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Chas P. Forde, M.D.</u> (Degree or title)	22b. ADDRESS <u>2801 N. Taylor</u>	22c. DATE SIGNED <u>3-4-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/7/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>
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24. FUNERAL DIRECTOR <u>Charles J. Gates</u> ADDRESS <u>4107 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 5 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

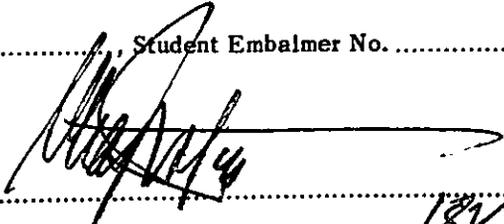
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. ~~4500~~ ¹⁸¹³

P. O. Address..4107 Finney.....

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.