

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027538

FILED VS JUL 21 1959

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1814 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood</b>		Length of stay in 1b <b>2 weeks</b>		c. CITY OR TOWN <b>Eureka</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt 1, Box 364</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>L.</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1959</b>									
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-18-86</b>		9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher - Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Schools</b>			11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Joseph Eckelkamp</b>				13b. MOTHER'S MAIDEN NAME <b>Agnes Ryan</b>				14. NAME OF HUSBAND OR WIFE <b>James Phillip Williams</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Dorothy Williams Rt 1, Eureka Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, Meningitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Organism unknown.</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease, Rheumatoid Arthritis</b>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? 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 Hour a.m. p.m.		Month, Day, Year											
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.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from <b>920 P</b> to <b>July 4, 1959</b> and last saw her/him alive on <b>July 4, 1959</b> Death occurred at <b>920 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Daved Kape Kers, MD</b>						22b. ADDRESS <b>930 Francis Pl. Clayton, Mo.</b>				22c. DATE SIGNED <b>7/6/59</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-7-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Remetery</b>				23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>		(State)			
24. FUNERAL DIRECTOR <b>Schrader Funeral Home Ballwin Mo.</b>					ADDRESS		25. DATE RECD. BY LOCAL REG. <b>7-6-59</b>		26. REGISTRAR'S SIGNATURE <b>C. Howe Peller</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard M. Bopp

Licensed Embalmer No. 4584

P. O. Address Ballewin,

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.