

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS AUG 24 1959**

**59-030901**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **2 7437** STATE FILE NUMBER

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>ST. LOUIS</b>                   |  | Length of stay in 1b<br><b>LIFE</b>  | c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>E/R to City Hospital</b> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>2312 Pestalozzi</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>CLARA</b> Middle <b>WILLIAMS</b> Last                                 |                                  |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>9</b> Year <b>1959</b> |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/30/14</b>                                    | 9. AGE (last birthday)<br><b>44</b>                   | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own Home</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Sappington, Mo.</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>          |   |
| 13a. FATHER'S NAME<br><b>George Dietrich</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Birschjusz</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Jasper Williams</b> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 16. SOCIAL SECURITY NO.   | 17. INFORMANT Address<br><b>Jasper Williams, 2312 Pestalozzi</b>      |   |   |

|   |   |  |
|---|---|--|
| 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) <b>Gastro Intestinal Hemorrhage</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Metastatic Cancer</b>                 |  |
|   | DUE TO (c) <b>Epidermoid Cancer of Cervix Uteri</b> |  |

|   |  |   |  |
|---|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|---|--|

|   |   |   |              |
|---|---|---|--------------|
| 19. WAS AUTOPSY PERFORMED?<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.)<br><b>none</b> |              |
| 20c. TIME OF INJURY<br><b>None</b> 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 **6/7/59** to **7/26/59** and last saw her/him alive on **7/26/59**  
 Death occurred at **6:40 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                               |   |   |
|--|-------------------------------|---|---|
| 22a. SIGNATURE (Degree or title)<br><b>James A. Brennan M.D.</b>         |                               | 22b. ADDRESS<br><b>5535 Dolmar.</b>                               | 22c. DATE SIGNED<br><b>8/10/59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>              | 23b. DATE<br><b>8/12/1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New St. Marcus Ceme.</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b> |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>McLAUGHLIN'S, 2301 Lafayette Ave.</b> |                               | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 10 '59</b>                 | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith, M.D.</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 *N. Y. Lewis*

Licensed Embalmer No. 3384

P. O. Address *N. Y. Lewis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.