

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 27 1960

318

Primary Registration District No. 1003

Registrar's No. 5926

-60-025108

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO</u>		Length of stay in 1b		c. CITY OR TOWN <u>St Louis Missouri</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. LOUIS CITY HOSP. #1.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2204 A Menard Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ELY</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>8,</u> Year <u>1960</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>6/14/76</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Stella</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.		17. INFORMANT Address <u>Stella Williams 2204 A Menard Str</u>			
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>Uremia</u> DUE TO (b) <u>HYDROPYONEPHROSIS</u> DUE TO (c) <u>CHRONIC PYELONEPHRITIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized advanced arteriosclerosis - Emphysema</u>					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 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.) <u>600.0</u>				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.								
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 <u>5/27/60</u> to <u>6/8/60</u> and last saw her/him alive on <u>6/8/60</u> Death occurred at <u>10:15 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert J. Westerhede, M.D.</u>				22b. ADDRESS <u>1515 LAFAYETTE A VE</u>			22c. DATE SIGNED <u>6/8/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Hy 40</u>		23d. LOCATION (City, town, or county) (State) <u>St Charles Missouri</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Moydell Funeral Home 1926 Allen</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 9 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>		

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 Halley P. Jaeller Jr
Licensed Embalmer No. 4950
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.