

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 9 1960

60-040674

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3134

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST LOUIS</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                       |  | Length of stay in 1b<br><u>4 wks.</u>   | c. CITY OR TOWN <u>St. Johns</u><br>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 <u>Mt. St. Rose Hospital</u> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><u>9047 Pallardy</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Dorothy E</u> Middle <u>Williams</u> Last <u>Williams</u>             |                                  |   | 4. DATE OF DEATH<br>Month <u>Oct</u> Day <u>26</u> Year <u>1960</u>       |   |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 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><u>2/11/1907</u>                                      | 9. AGE (last birthday)<br><u>53</u>                     | 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><u>Housewife</u>       |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Courtland, Kansas</u>    |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u> |
| 13a. FATHER'S NAME<br><u>August Hallberg</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Ida May Squires</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Ernest M Williams</u> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  | 17. INFORMANT Address<br><u>Ernest M Williams 9047 Pallardy St. Johns</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) Carcinoma of Lungs INTERVAL BETWEEN ONSET AND DEATH 2 years

DUE TO (b) Cigarettes

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
Pericarditis, fibrosis

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  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.) |  |
| 20c. TIME OF INJURY<br>Hour: _____ a.m. _____ p.m.<br>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<br><u>St. Louis</u> | COUNTY<br><u>Mo</u> | STATE<br><u>Mo</u> |
| 21. I attended the deceased from <u>October 1959</u> to <u>October 26, 1960</u> and last saw her <u>him</u> alive on <u>Oct. 25, 1960</u><br>Death occurred at <u>6 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |  |                     |                    |

|  |  |  |  |
|--|--|--|--|
| 22a. SIGNATURE (Degree or title)<br><u>[Signature]</u>         | 22b. ADDRESS<br><u>6500 Chippewa - St. L. Mo</u> | 22c. DATE SIGNED<br><u>10/26/60</u><br>(State)           |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify)<br><u>Funeral</u> | 23b. DATE<br><u>Oct 29, 1960</u>                 | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Laurel Hill</u> | 23d. LOCATION (City, town, or county)<br><u>St. Louis Co. Mo</u> |

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Ortmann F. Home 9222 Lackland Overland</u> | 25. DATE RECD. BY LOCAL REG.<br><u>10-28-60</u> | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |
|---|---|---|

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

561-4105

NOV 20 1960

**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 Al C. O. [Signature]

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.