

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4232-61-019630  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4232**

FILED MAY 19 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE			b. COUNTY			c. CITY OR TOWN			d. STREET ADDRESS			e. INSIDE LIMITS			f. RESIDE ON FARM		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b			c. CITY OR TOWN <b>St. Louis</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS <b>2656 A. Delmar</b>			f. RESIDE ON FARM Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2656 A. Delmar</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS <b>2656 A. Delmar</b>			f. RESIDE ON FARM Yes <input type="checkbox"/> No <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth Williams</b>						4. DATE OF DEATH Month Day Year <b>5 3 61</b>														
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</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>5/12/1900</b>		9. AGE (last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Moneys, Miss.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>											
13a. FATHER'S NAME <b>Will Hester</b>				13b. MOTHER'S MAIDEN NAME <b>Lena Hogan</b>				14. NAME OF HUSBAND OR WIFE <b>George 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>						17. INFORMANT Address <b>Mary Wright-779 Euclid</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>Pulmonary Edema,</b> DUE TO (b) <b>Chronic Myocarditis with decompensation.</b> DUE TO (c) <b>422.2</b>												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)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown										
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)																
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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>10:20 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.																				
22a. SIGNATURE (Degree or title) <i>John E. Hester</i>						22b. ADDRESS <b>1500 Elm</b>			22c. DATE SIGNED <b>5/14</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-9-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>			23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRACKS, MO.</b>													
24. FUNERAL DIRECTOR ADDRESS <b>A.L. Beal Und.Co. -4303 Delmar</b>						25. DATE RECD. BY LOCAL REG. <b>MAY 4 1961</b>		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>												

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Arthur L. Heilbard*

Licensed Embalmer No.

*4221*

P. O. Address

*3100 Easton*

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.