

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

-61-027506

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **6938**

AMENDED

**FILED AUG 3 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
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>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4419 SO Grand Blvd</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4419 So Grand Blvd</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>A</b> Last <b>WILLIAMSON</b>	4. DATE OF DEATH Month <b>&amp;</b> Day <b>17</b> Year <b>1961</b>
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5. SEX <b>Male</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>2-3-1882</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>	11. BIRTHPLACE (City and state or country) <b>Cleburne Texas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John J Williamson</b>	13b. MOTHER'S MAIDEN NAME <b>Not Known</b>	14. NAME OF HUSBAND OR WIFE <b>Flora Hayes Williamson</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or Unknown) <b>NAVY</b> (If yes, give dates of service) <b>NAVY</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Flora Williamson 4419 So Grand Blvd.</b>
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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>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic Heart Disease</b>	
	DUE TO (c) <b>Renal Arteriosclerosis</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Osteoarthritis, generalized</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year	<b>420.0</b>
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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
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21. I attended the deceased from <b>May 27, 61</b> and last saw him alive on <b>7/24/61</b> Death occurred at <b>2:15 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Caron Herdler MD</b> (Degree or title)	22b. ADDRESS <b>4268 Delar</b>	22c. DATE SIGNED <b>7/26/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-27-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jeff. Barracks Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Wingbermuehle 3819 So Grand Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 26 1961</b>	26. REGISTRAR'S SIGNATURE <b>Coal Smith MD</b>
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Geo. J. Bergemann*

Licensed Embalmer No. 4611

P. O. Address Albany 18

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.