SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-035515
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2598

FILED SEP 27 1961

1. PLACE OF DEATH
a. COUNTY: Saint Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Valley Park — Length of stay in 1b: 9 mos.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Valley Park Nursing Home — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Franklin
c. CITY OR TOWN: St. Clair — Inside Limits: Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Myrtle Middle: Hudson Last: Williams
4. DATE OF DEATH: Month: Sept. Day: 13 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 2/13/1867
9. AGE (last birthday): 94
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Ohio
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: William Hudson
13b. MOTHER'S MAIDEN NAME: Mathilda Sullivan
14. NAME OF HUSBAND OR WIFE: Allen George Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Myra Beasley, St. Clair, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) – Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Jan. 4, 1961, to Sept. 13, 1961 and last saw her alive on Sept. 10, 1961
Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert Sanders (Degree or title): M D
22b. ADDRESS: 1507 Case Av. St. Louis
22c. DATE SIGNED: 9-14-61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Sept. 16, '61
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
23d. LOCATION (City, town, or county) (State): Lonedell, Missouri

24. FUNERAL DIRECTOR: Casey-Lenox ADDRESS: St. Clair, Mo.
25. DATE RECD. BY LOCAL REG.: 9-15-61
26. REGISTRAR'S SIGNATURE: John C. Mangelsdorf M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | 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 Willard L. Strauser, Student Embalmer No. 623 working under my personal supervision.

Student Willard L Strauser
Signature of Student Embalmer

Signed K M Lenox

Licensed Embalmer No. 3601

P. O. Address St Clair Mo.

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.