

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046207

Registration District No. 318  
FILED NOV 22 1963

Primary Registration District No. 1003

Registrar's No. 11440

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE No. b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 2 1/2 Weeks	c. CITY OR TOWN Crestwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9248 Levant Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last FRED B. WILLIAMS		4. DATE OF DEATH Month Day Year Nov. 16 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1884
9. AGE (last birthday) 78		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) Electrical Motor Repairing		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	11. BIRTHPLACE (City and state or country) Shrewsbury, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William Ward Williams	
13b. MOTHER'S MAIDEN NAME Sarah McClain		14. NAME OF HUSBAND OR WIFE Elizabeth Rose Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. INFORMANT Address William A. Williams 9248 Levant Dr.	
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>OBSTRUCTION, CIRRHOSIS OF LIVER OBSTRUCTIVE</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>arteriosclerosis, chronic alcoholism, former</u> DUE TO (c) <u>446x</u> 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 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 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>10/30/62</u> to <u>11/16/62</u> and last saw him alive on <u>11/16/62</u> Death occurred at <u>9:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph D. Swype, M.D.</u>		22b. ADDRESS <u>3228 Junbre Pkwy Mo.</u>	
22c. DATE SIGNED <u>11/18/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11/20/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u>	
24. FUNERAL DIRECTOR <u>Alexander &amp; Sons 6175 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 19 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

Dr. Swope

3228 Ivanhoe

2:00

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 J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address H.L.

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.

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