S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 18 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 33109

Registrar's No. 8476

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3649 Laclede 9
(If rural, give location)

Memorial 19

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME WILLA VILEY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, ~~divorced~~ widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 4 (Day) 1859 (Year)

8. AGE: Years 88 Months 3 Days 1 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business "

FATHER
12. Name Unknown
13. Birthplace " 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " 9 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs L. Leishman
(b) Address 3649 Laclede

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6-46 (Month) (Day) (Year)
(c) Place: burial or cremation St Matthews

18. (a) Signature of funeral director E. J. Schnure
(b) Address 3125 Lafayette

19. (a) SEP 6 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5th year 1947 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from 8/23/47, 19, to Sept. 5th 1947 that I last saw him alive on Sept. 5th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Stomach months

Due to 46

Due to

Other conditions Generalized Arteriosclerosis Years
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Not done

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence None

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)

While at work? (e) Means of injury

23. Signature Robert L. Gilbert 9/5/47 (Date of other) M.D.

Address Date signed

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.