

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

41949

State File No. _____
Registrar's No. 11338

Registration District No. 318

Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3-hours
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Edmund A. Willoughby

3. (b) If veteran, name war World War # 1 3. (c) Social Security No. _____

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Marjorie Willoughby 6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased Dec. 20th., 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 0 8 hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)
Chauffeur

10. Usual occupation Public Service Corp.

11. Industry or business _____

12. Name George F. Willoughby
13. Birthplace Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Kate Heron
15. Birthplace Penn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marjorie Willoughby
(b) Address 6927 Fyler Ave.

17. (a) Burial (b) Date thereof 12-31-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pat. Cemetery, Jefferson Barracks

18. (a) Signature of funeral director Patrick J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) DEC 29 1948 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 6927 Fyler Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28th.,
year 1948 hour 8 minute a. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Apoplexy Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to 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 _____
(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? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury Patrick J. Donnelly
23. Signature Patrick J. Donnelly (M. D. or other) _____
Address 1500 Clark Date signed 12-29-48

JAN 20 1949

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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..... *W. H. ...*

Licensed Embalmer No. *2525*

P. O. Address *4541 ...*

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.

201110 S. IANOLIO