

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2830

State File No. ....

152

FILED JAN 19 1949

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|   |  |   |            |  |                       |  |  |
|---|--|---|------------|--|-----------------------|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. _____  |            | PRIMARY REG. DIST. NO. _____   |                       | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |            | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY <u>DOU</u> |                       |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>   |  | c. LENGTH OF STAY (In this place) _____   |            | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>  |                       | 17   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>  |  |   |            | d. STREET ADDRESS (If rural, give location) <u>3112 Market St</u>  |                       |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Willette</u>  |  |   | a. (First) | b. (Middle)  | c. (Last) <u>Inge</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Jan. 5 1949</u>                      |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>Colored</u>   |            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>  |                       | 8. DATE OF BIRTH <u>St. Louis, Mo. 4-40</u>                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |            | 11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>  |                       | 12. CITIZEN OF WHAT COUNTRY? _____   |  |
| 13a. FATHER'S NAME <u>WILL THOMAS</u>   |  | 13b. FATHER'S MAIDEN NAME <u>DAISY TURNER</u>   |            | 14. NAME OF HUSBAND OR WIFE <u>CHARLES</u>   |                       |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  | 16. SOCIAL SECURITY NO. _____   |            | 17. INFORMANT'S SIGNATURE OR NAME <u>Charles Inge</u> ADDRESS _____  |                       |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio-nephrosclerosis</u><br><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Undetermined</u><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Broncho pleural fistula</u> |            |  |                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>Undet.</u>                                |  |
| 19a. DATE OF OPERATION<br><u>None</u>   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |            |  |                       | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |            | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |                       |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |            | 21f. HOW DID INJURY OCCUR? _____   |                       |  |  |
| 22. I hereby certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>49</u> , to <u>Jan 5</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Jan. 5</u> , 19 <u>49</u> , and that death occurred at <u>6 a</u> m., from the causes and on the date stated above. |  |   |            |  |                       |  |  |
| 23a. SIGNATURE <u>Herbert J. Curran</u> (Degree or title) <u>M. D.</u>  |  |   |            | 23b. ADDRESS <u>2601 N Whittier St</u>   |                       | 23c. DATE SIGNED <u>1/6/49</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 24b. DATE <u>1-8-1949</u>   |            | 24c. NAME OF CEMETERY OR CREMATORY <u>FATHER PICKSON</u>   |                       | 24d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo</u>                 |  |
| DATE REC'D BY LOCAL REG. <u>JAN 7 1949</u>  |  | REGISTRAR'S SIGNATURE <u>J. B. Foster</u>   |            | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernie Love</u> ADDRESS <u>3103 Washington</u>   |                       |  |  |

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

**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.

Signed.....

*W. Claude Gordon*

Signed.....

Student Embalmer

Licensed Embalmer No. 3489

P. O. Address. 4575 Aldine

**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.