

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10825

State File No.

318

1003

3129

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.,		c. LENGTH OF STAY (In this place) Life,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,				
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys Hospital				d. STREET ADDRESS (If rural, give location) 3814 Chippewa,				
3. NAME OF DECEASED (Type or Print) Celia Willman			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH		(Month)		(Day)		(Year)		
4/5/49								
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 5/15/1898		
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 10		IF UNDER 1 YEAR Days 20		IF UNDER 1 YEAR 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 none			11. BIRTHPLACE (State or foreign country) St. Louis, Mo.,		
12. CITIZEN OF WHAT COUNTRY? USA								
13a. FATHER'S NAME John Clement			13b. MOTHER'S MAIDEN NAME ? Keterer			14. NAME OF HUSBAND OR WIFE Oliver		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oliver Willman 3814 Chippewa,				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) astrocytoma				INTERVAL BETWEEN ONSET AND DEATH 35 days				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES				
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) 5H				
DUE TO (c) 193X								
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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) (Minute)		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 3/31, 1949, to 4/5, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at 10 a.m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Charles C. Drake M.D.				23b. ADDRESS 3707 Gravois		23c. DATE SIGNED 4/6/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4/8/49		24c. NAME OF CEMETERY OR CREMATORY Resurrection		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. APR 7 1949		REGISTRAR'S SIGNATURE J. B. Sauter		EMBALMER'S SIGNATURE OSCAR J. RUFFMEISTER UND. CO. 4016 CHIPPEWA ST.				

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

Handwritten mark

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 _____

Frank J. [Signature]
Licensed Embalmer No. *2675*
P. O. Address *[Signature]*

Signed _____
Student Embalmer

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.