

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18787

State File No. 1854

#110390

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1023 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		a. STATE Missouri	b. COUNTY
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 2704a So. 11th St., 0	

3. NAME OF DECEASED (Type or Print)	a. (First) John	b. (Middle) Willer	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) May 13th, 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Dec. 31, 1882	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 13	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman	10b. KIND OF BUSINESS OR INDUSTRY Mo. Pattern Works	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Willer	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lillian Willer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 492-07-4809	17. INFORMANT'S SIGNATURE OR NAME Ann Zwicke	ADDRESS 6651 Winona Ave.,
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma of prostate</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
	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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 177X
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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?
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22. I hereby certify that I attended the deceased from 4/11/50, 19, to 5/13/50, 19, that I last saw the deceased alive on 5/13/50, 19, and that death occurred at 1:15 pm m., from the causes and on the date stated above.

23a. SIGNATURE <i>W.W. Carter, M.D.</i>	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 5/14/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/16/50	24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS AT, Louis, Mo	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. MAY 15 1950	REGISTRAR'S SIGNATURE <i>W.W. Carter</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas K. ...</i>	ADDRESS 2906 ...
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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.

Student .....  
Student Embalmer

Signed *James C Dill* .....

Licensed Embalmer No. *4347* .....

P. O. Address *2906 Garrison* .....

**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.