

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25499

FILED AUG 7 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6728

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2039	
d. FULL NAME OF HOSPITAL OR INSTITUTION PARK LANE HOSPITAL		d. STREET ADDRESS (If rural, give location) 6262 MARMADUKE	
3. NAME OF DECEASED (Type or Print) a. (First) PAUL		b. (Middle) M.	
c. (Last) WILL		4. DATE OF DEATH (Month) (Day) (Year) JULY 27 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Nov. 13 1870
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) INDIANA
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME JOHN WILL	
13b. MOTHER'S MAIDEN NAME MARY RHODE		14. NAME OF HUSBAND OR WIFE MARGARET WILL (DECEASED)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME ALBERT J. WILL		ADDRESS 1920 McCAUSLAND	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Lung</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma Larynx</u> 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 X Ray Chest	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 161X			
22. I hereby certify that I attended the deceased from May 30, 1951, to July 27, 1951, that I last saw the deceased alive on 7/27, 1951, and that death occurred at 3:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE T. B. Capel (Degree or title)		23b. ADDRESS 3284 Franklin Ave	
23c. DATE SIGNED 7/28/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JULY 30 1951	
24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.		24d. LOCATION (City, town, or county) ST. LOUIS MO.	
DATE REC'D BY LOCAL REG. JUL 29 1951		REGISTRAR'S SIGNATURE J. B. Laster	
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis		ADDRESS 2906 Gravois	

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

3284 Bramble
Kli 2502
1076 14 morning lot

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 _____

James P. Hill

Signed _____
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Ham

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.