

FILED AUG 7 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

120 R Ray

25637

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 2724

1. PLACE OF DEATH  
a. COUNTY St Louis  
b. CITY OR TOWN Richmond Heights  
c. LENGTH OF STAY (in this place) 4 days  
d. FULL NAME OF HOSPITAL OR INSTITUTION St Marys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri  
b. COUNTY St Louis  
c. CITY OR TOWN St Louis  
d. STREET ADDRESS (If rural, give location) 632 Columbia

3. NAME OF DECEASED  
a. (First) William b. (Middle) \_\_\_\_\_ c. (Last) Helming

4. DATE OF DEATH (Month) (Day) (Year) 7-20-1951

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH 11-19-1889 9. AGE (In years last birthday) (If under 1 year: Months) (Days) (Hours) (Min.) 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (State or foreign country) Caseyville Twp Ill 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Fulton 13b. MOTHER'S MAIDEN NAME Katherine Hoffman 14. NAME OF HUSBAND OR WIFE Clarence

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. \_\_\_\_\_ 17. INFORMANT'S SIGNATURE OR NAME Clarence Helming ADDRESS 632 Columbia

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, ashenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Adenocarcinoma of ovary  
ANTECEDENT CAUSES with metastases to intestine DUE TO (b) generalized  
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  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) \_\_\_\_\_

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from 20 May, 1950, to 20 July, 1951, that I last saw the deceased alive on 20 July, 1951, and that death occurred at 10:28 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Richard M. May, M.D. 23b. ADDRESS 5930 Southwest 23c. DATE SIGNED \_\_\_\_\_

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 7-21-1951 24c. NAME OF CEMETERY OR CREMATORY St Johns Cem 24d. LOCATION (City, town, or county) (State) Collinsville Ill

DATE REC'D BY LOCAL REG. 7-20-51 REGISTRAR'S SIGNATURE Theodore P. Donke, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc.

WRITE PLAINLY—USING UNFAADING 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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed John Ketter

Licensed Embalmer No. 3880

P. O. Address Albany N.Y.

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.