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FILED JUL 19 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25751  
Registrar's No. 2630

BIRTH NO. _____		REG. DIST. NO. <u>37</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>2630</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>High View Acres</u>		c. LENGTH OF STAY (In this place) <u>2 Wks.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rock Hill</u>		4631	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Halls Ferry Memorial Home</u>				d. STREET ADDRESS (If rural, give location) <u>8950 Manchester</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Wilhelmina</u> b. (Middle) <u>E.</u> c. (Last) <u>Laws</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>7</u> <u>9</u> <u>51</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>July 23, 1874</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Von Stulpnagel</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas J. Laws</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Ruth T. Laws</u>		ADDRESS <u>Arlington Mo.</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrovascular accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>June 20/51</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> <u>Yes.</u> DUE TO (c) <u>Hypertension</u> <u>Yes</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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?			
22. I hereby certify that I attended the deceased from <u>June 20, 1951</u> , to <u>July 9, 1951</u> , that I last saw the deceased alive on <u>July 6, 1951</u> , and that death occurred at <u>8:20</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Lewis E. Liffmann M.D.</u>				23b. ADDRESS <u>8237 Clayton</u>		23c. DATE SIGNED <u>July 11/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/12/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-11-51</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Lomke Md</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Colliers Funeral Home</u> ADDRESS <u>10133 St. Charles Rd</u>			

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

Dr. Bernard Halliday

To: Bernard Kelly,

Fr. 10.25.

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

*Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *10123 St. Charles*

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.