

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30192

WED AUG 23 1952

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State File No.

7582

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <i>Missouri - Baptist Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY <i>Pike</i>			
b. CITY OR TOWN <i>St. Louis, Mo.</i>		c. LENGTH OF STAY (in this place) <i>10 days</i>		c. CITY OR TOWN <i>New Hartford</i>		d. STREET ADDRESS (If rural, give location) <i>0820</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Missouri Baptist Hospital</i>							
3. NAME OF DECEASED (Type or Print) a. (First) <i>WILLIAM</i>			b. (Middle) <i>MALE</i>			c. (Last) <i>WILLIS</i>	
4. DATE OF DEATH (Month) (Day) (Year) <i>8-3-52</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i>		8. DATE OF BIRTH <i>April 13, 1931</i>	
9. AGE (in years last birthday) <i>15</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Pike</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>Otto Willis</i>		13b. MOTHER'S MAIDEN NAME <i>Ruth Reese</i>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Otto Willis, New Hartford, Mo.</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Brain Tumor, Obstructive Hydrocephalus.</i>				INTERVAL BETWEEN ONSET AND DEATH	
		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. <i>Increased Intracranial Pressure.</i>					
19a. DATE OF OPERATION <i>4-5-52</i>		19b. MAJOR FINDINGS OF OPERATION <i>Increased Intracranial Pressure.</i>				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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>752X</i>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>8-3</i> , 1952, and that death occurred at <i>2 P.</i> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Leland M. Memme (F.A.P.)</i>				23b. ADDRESS <i>4952 Maryland</i>		23c. DATE SIGNED <i>8-6-52</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>8-5-52</i>		24c. NAME OF CEMETERY OR CREMATORY <i>5910 1/2 N. Peabody</i>		24d. LOCATION (City, town, or county) (State) <i>Pike Co. Mo.</i>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <i>AUG 8 1952</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>M. H. Beck</i>		ADDRESS <i>Louisiana, Mo.</i>	

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

