

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12535**
Registrar's No. **2094**

FILED MAR 18 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 21 3127 Locust St. 0	
3. NAME OF DECEASED a. (First) WILLIAM b. (Middle) H. c. (Last) WILLIAMS			4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 21, 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 3	8. DATE OF BIRTH July 26, 1893
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector	11. BIRTHPLACE (City and State or Foreign Country) Warsaw, Wisconsin
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) inspector		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Armature	12. CITIZEN OF WHAT COUNTRY 1
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Florence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 498-05-6247	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eddie Broyles 3300 Olive St.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia, B.L.L. ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes Mellitus DUE TO (c) Benign Prostatic Hypertrophy II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 490X			
22. I hereby certify that I attended the deceased from 2-14-53 , 19 53 , to 2-21-53 , 19 53 , that I last saw the deceased alive on 2-21-53 , 19 53 , and that death occurred at 9:35P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ridolb E. Catanzaro M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 2-23-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 2-25-53 n	
24c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. FEB 24 1953		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. Kron I&U. Co. 2707 N. Grand Blvd.	

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 Ronald O Yahrke

Licensed Embalmer No. 31917

P. O. Address Peris

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.