

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41397**
Registrar's No. **10870**

FILED NOV 27 1953

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

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | c. LENGTH OF STAY (In this place) 1 wk | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Incarinate Throat Hosp. | | e. STREET ADDRESS (If rural, give location) 17 3839 McRee | |

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|--|--------------------------|-----------------------------|--|------------------|---------------------|
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH (Month) (Day) (Year) | | |
| a. (First) Charles | b. (Middle) J. | c. (Last) Willman | Month 11 | Day 14 | Year 1953 |

| | | | | | | | | |
|--------------------|------------------------------|--|---|--|------------------------|------------------------|-----------------------|--------------------------|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M | 8. DATE OF BIRTH May 20, 1881 | 9. AGE (In years last birthday) 72 | 10. MONTHS 6 | 11. YEARS 25 | 12. HOURS 1 | 13. MINUTES 25 |
|--------------------|------------------------------|--|---|--|------------------------|------------------------|-----------------------|--------------------------|

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|--|--|--|--|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Louis Mall Co. | | 11. BIRTHPLACE (City and State or Foreign Country) Ill. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
|--|--|--|--|---|--|---|--|

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME John Hillman | | 13b. MOTHER'S MAIDEN NAME Elizabeth Feder | | 14. NAME OF HUSBAND OR WIFE Louise | |
|---|--|---|--|--|--|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. 494-07-9609A | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. L. Hillman 3839 McRee | | | |
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| 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. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of | | | | |
| | | DUE TO (c) prostate with metas- | | | 2 yrs | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. toxic | | | | |

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|------------------------|----------------------------------|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|----------------------------------|--|--|--|--|

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| 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) |
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| | | |
|--|--|---|
| 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? 177X |
|--|--|---|

22. I hereby certify that I attended the deceased from **1951** to **11-14-**, 19**53**, that I last saw the deceased alive on **11-14-**, 19**53**, and that death occurred at **11:30P** m., from the causes and on the date stated above.

| | | | |
|---|--|----------------------------------|-------------------------------------|
| 23a. SIGNATURE (Degree or title) D. S. Michael M.D. | | 23b. ADDRESS 572 Olive | 23c. DATE SIGNED 11/16/53 |
|---|--|----------------------------------|-------------------------------------|

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|---|------------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 11/18/53 | 24c. NAME OF CEMETERY OR CREMATORY Mauney Cemetery | 24d. LOCATION (City, town, or county) (State) Mauney Illinois |
|---|------------------------------|--|---|

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|--|--|---|----------------------------------|
| DATE REC'D BY LOCAL REG. NOV 16 1953 | REGISTRAR'S SIGNATURE J. Cash Smith M.D. | FUNERAL DIRECTOR'S SIGNATURE W. A. Howard | ADDRESS 1619 So. Grand |
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*.....

Licensed Embalmer No. *4787*.....

P. O. Address *St. Louis Mo.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.