

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44426

State File No. \_\_\_\_\_

FILED JAN 5 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 11984

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8418 Pennsylvania ave.		d. STREET ADDRESS (If rural, give location) 8418 Pennsylvania ave.	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) L. c. (Last) Pils			4. DATE OF DEATH (Month) (Day) (Year) December 17, 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 1, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper hanger		10b. KIND OF BUSINESS OR INDUSTRY Wall Paper & Decorating	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME William L. Pils		13b. MOTHER'S MAIDEN NAME Augusta Richman	14. NAME OF HUSBAND OR WIFE Sophia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sophia Pils
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis 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 <input 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR		331X	
22. I hereby certify that I attended the deceased from Jan 26, 1953, Dec 17, 1953, that I last saw the deceased alive on Dec 17, 1953, and that death occurred at 6:30 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) L. C. Mueller M.D.		23b. ADDRESS 3537 S. Jefferson	
23c. DATE SIGNED Dec 18/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec. 21, 1953	
24c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		24d. LOCATION (City, town, or county) (State) 2000 Lemay Ferry Road Lemay	
DATE REC'D BY LOCAL REG. DEC 21 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 7814 S. Broadway			

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 .....

Student Embalmer

Signed

*Harry J. Schencker*

Licensed Embalmer No. *2679*

P. O. Address *7814 S. Broadway*

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.