

FILED MAY 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 13755

Registrar's No. 3814

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 13755	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (If this place) <b>8 days</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>20 2601 Hebert St. 2209</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b>		b. (Middle) <b>Earl</b>		c. (Last) <b>PAGE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>APRIL 28, 1955</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 27, 1890</b>		9. AGE (In years last birthday) <b>64</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Columbia, Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>William Walker Page</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Helen S. _____</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>488-18-3809</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Helen S. Page 2601 Hebert St.</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchogenic carcinoma</b>  ANTECEDENT CAUSES Morbidity 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.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		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) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>162x</b>			
22. I hereby certify that I attended the deceased from <b>4-20-55</b> , 19____, to <b>4-28-55</b> , 19____, that I last saw the deceased alive on <b>4-28-55</b> , 19____, and that death occurred at <b>12:05A</b> ., from the causes and on the date stated above.							
23a. SIGNATURE <b>Frank Williams MD</b> (Degree or title) _____				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>4-28-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>April 30, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>4946 W. Florissant ave.</b>	
DATE REC'D BY LOCAL REG. <b>APR 29 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C. Hoffmeister Colonial Mortuary 646 Chippewa St.</b>			

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 *Linus C. Hoffmann*

Licensed Embalmer No. 387

P. O. Address 7814 SB

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.