

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17127**
4605

FILED JUN 10 1955

318

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BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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

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1. PLACE OF DEATH a. COUNTY 1		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY SHANNON	
b. CITY OR TOWN Saint Louis Mo. D.O.A.		c. CITY OR TOWN Clayden 101st	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST Louis Childrens		STREET ADDRESS (If rural, give location) RECTOR ROUTE	

3. NAME OF DECEASED (Type or Print) a. (First) KENNETH b. (Middle) GENE c. (Last) Willis	4. DATE OF DEATH (Month) (Day) (Year) 5-25-55
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 4-22-43	9. AGE (In years last birthday) 12	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) RECTOR Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME SHERMAN K. Willis	13b. MOTHER'S MAIDEN NAME Opal Hodges	14. NAME OF HUSBAND OR WIFE None
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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. None	17. INFORMANT'S SIGNATURE OR NAME J. EGAN ADDRESS 500 So Kingshighway
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 18 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Brain Tumor		
	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.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 193X
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22. I hereby certify that I attended the deceased from **5-25**, 19**55**, to **5-25**, 19**55**, that I last saw the deceased alive on **5-25**, 19**55**, and that death occurred at **12:45** p.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. L. Smith (Degree or title) MD	23b. ADDRESS Childrens Hospital	23c. DATE SIGNED MAY 25 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-25-55	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Salem, Mo.
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DATE REC'D BY LOCAL REG. MAY 25 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.
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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 *Elmer K. Padwell*

Licensed Embalmer No. *40*

P. O. Address *St. Louis*

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.