

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31666**Registrar's No. **8265**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 31666			
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) St. Louis, Mo.			c. LENGTH OF STAY (In this place) 26 days		c. CITY OR TOWN St. Louis		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 Firmin Desloge Hospital				e. STREET ADDRESS (If rural, give location) 2701 N. Spring				2119	
3. NAME OF DECEASED (Type or Print) a. (First) Ernest		b. (Middle) W.		c. (Last) Willmzig		4. DATE OF DEATH (Month) (Day) (Year) 9 18 1955			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH JAN 5 - 1894		9. AGE (In years last birthday) 61	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) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY ST. LOUIS, DIE CAST		11. BIRTHPLACE (City and State or Foreign Country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13a. FATHER'S NAME EDGAR WILLMZIG			13b. MOTHER'S MAIDEN NAME LOUISE TARDO		14. NAME OF HUSBAND OR WIFE LEONA WILLMZIG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WAR I		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME LEONA WILLMZIG				ADDRESS 2701 N SPRING	
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) Generalized Sepsis						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Advanced Esophageal CARCINOMA OF ESOPHAGUS							
		DUE TO (c) Post op Complications							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. for Esophageal Cancer							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION CARCINOMA OF ESOPHAGUS with metastases						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
				150 N					
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?					
22. I hereby certify that I attended the deceased from Aug. 27, 1955 , to Sept. 8, 1955 , that I last saw the deceased alive on Sept 17, 1955 , and that death occurred at 4 p. m. , from the causes and on the date stated above.									
23a. SIGNATURE Rollin H. Taylor M.D.				(Degree or title)		23b. ADDRESS 1325 S. Grand Blvd.		23c. DATE SIGNED Sept 19, 1955	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE SEPT 21 - 1955		24c. NAME OF CEMETERY, OR CREMATORY NATIONAL CEM		24d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS ST MO			
DATE REC'D BY LOCAL REG. SEP 20 1955		REGISTRAR'S SIGNATURE J. Cash Smith		25. FUNERAL DIRECTOR'S SIGNATURE Mr. Thomas Kuba					
				ADDRESS 2906 Gravia					

(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 *H. H. Howell*
Licensed Embalmer No. *43*

Licensed Embalmer No. *43*

P. O. Address *2906 St*

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.