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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 36339

FILED NOV 16 1956 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8976

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Anthony Hospital — Length of stay in Ib 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St.Louis — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 8209 S.Broadway — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Jean Middle R. Last Villiers
4. DATE OF DEATH Month Sept. Day 30 Year 1956
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH October 28,1896
9. AGE (In years last birthday) 59 — 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) Optometrist
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (City and state or country) Baton Rouge, Louisiana
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW*1
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs.Vivian A.Colombo 8512 a Water St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatitis & obstructive jaundice and intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Echinococcus Cyst of Liver — yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 125X
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 9,'56 to Sept. 30,'56 and last saw him alive on Sept. 30-'56
Death occurred at 1.30 p. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George A. O'Sullivan, M.D.
22b. ADDRESS 7629 Ivory St Louis 11 Mo.
22c. DATE SIGNED Oct 1-1956

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Oct.3,1956
23c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery
23d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Lemay 23, Mo.

24. FUNERAL DIRECTOR C.Hoffmeister U.&L.Co. ADDRESS 7814 S.Broadway
25. DATE RECD. BY LOCAL REG. OCT 1 1956
26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

office 1 - 3pm

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student .....
Signature of Student Embalmer

Signed Louis C. Hoffman

Licensed Embalmer No. 38

P. O. Address 7814 S.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.