

Health, Welfare & Public Service

380
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part II must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15689
STATE FILE NUMBER

FILED MAY 3 - 1957

Registration District No. 310 Primary Registration District No. 590 Registrar's No. 896

1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) Shrewsbury		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5104 Michael Ave.		Length of stay in lb 3 wks.	d. STREET ADDRESS 3810 Lafayette (give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) William M. Letz First Middle Last			4. DATE OF DEATH April 12, 1957 Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, ?	9. AGE (In years last birthday) Abt. 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marble Finisher Ret.		10b. KIND OF BUSINESS OR INDUSTRY Building Trades	11. BIRTHPLACE (City and state or country) La Grange Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dent Know			14. MOTHER'S MAIDEN NAME Dent Know		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) No.		16. SOCIAL SECURITY NO. 498-07-4841a	17. INFORMANT Address Mrs. Clara Geile Letz 3810 Lafayette		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA URINARY BLADDER -					INTERVAL BETWEEN ONSET AND DEATH 15 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 Feb 20, 1957 to MARCH 8, 1957 and last saw ^{her} him alive on MARCH 8, 1957 Death occurred at 7 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John F Mackey MD			22b. ADDRESS 3720 WASHINGTON		22c. DATE SIGNED 4-3-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 5, 1957	23c. NAME OF CEMETERY OR CREMATORY Resurrection		23d. LOCATION (City, town, or county) (State) St. Louis missouri
24. FUNERAL DIRECTOR Thomas J. Finan 1519 S. Grand Blvd			25. DATE RECD. BY LOCAL REG. 4-4-57	26. REGISTRAR'S SIGNATURE Herbert A. Donleoh	

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 *Stanley H. Ripon*.....

Licensed Embalmer No. *419*

P. O. Address *H. L.*

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.