

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30183**  
Registrar's No. **6802**

FILED AUG 30 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) <b>St. Louis</b>		c. CITY OR TOWN <b>Overland Park Ave</b>	
c. LENGTH OF STAY (in this place) <b>1 day</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>Jewish Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>10743 Thorpe Avenue</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Kenneth</b>	b. (Middle) <b>Dale</b>	c. (Last) <b>Willis</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 20, 1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED, <input checked="" type="checkbox"/> SEPARATED	8. DATE OF BIRTH <b>July 19, 1957</b>	9. AGE (In years last birthday) 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) <b>nil</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>nil</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Kenneth D. Willis</b>	13b. MOTHER'S MAIDEN NAME <b>Sandra Hudson</b>	14. NAME OF HUSBAND OR WIFE <b>XXXXXXXXXXXXXXXXXX</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Kenneth D. Willis</b>	ADDRESS <b>10743 Thorpe Ave.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Atelectasis</b> <b>atelectases:</b>		<b>1 day</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Prematurity</b> DUE TO (c) <b>762.5</b>		
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)
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?

22. I hereby certify that I attended the deceased from **July 19, 1957**, to **July 20, 1957**, that I last saw the deceased alive on **July 20, 1957**, and that death occurred **2:45 P** m., from the causes and on the date stated above.

23a. SIGNATURE <b>P. Friedman</b>	(Degree or title) <b>M.D., M.D. Jewish Hospital</b>	23b. ADDRESS <b>Jewish Hospital</b>	23c. DATE SIGNED <b>7-21-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>7-23-1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>	24d. LOCATION (City, town, or county) (State) <b>Pagedale, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>III 2257</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>William Woodson</b>	ADDRESS <b>2504 Woodson Rd - Overland-14-Mo.</b>
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(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 *Loren E. Percy*

Licensed Embalmer No.....<sup>4</sup>

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.