

XC # 154 76 16

SL 14416 FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33911

STATE FILE NUMBER 8181

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>DESOTO</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS. A DM. HOSP.</b>		d. STREET ADDRESS <b>304 NORTH 11TH</b>	
Length of stay in lb <b>28 DAYS</b>		Reside on Farm <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM MOTLEY</b>			4. DATE OF DEATH Month Day Year <b>8-30-57</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-88</b>	9. AGE (In years (birth day)) <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	11. BIRTHPLACE (City and state or country) <b>PARSONS, KANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM MOTLEY</b>			14. MOTHER'S MAIDEN NAME <b>JOSEPHINE DICKSON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>547-03-8857</b>	17. INFORMANT Address: <b>VA HOSPITAL RECORDS, ST. LOUIS, MISSOURI</b>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUPLICATE (b) <b>CEREBRAL VASCULAR ACCIDENT</b>	<b>UNKNOWN</b>
	DUPLICATE (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>	<b>UNKNOWN</b>
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"/> <b>2</b>

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.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>VA</b>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. Attended the deceased from <b>8-2-57</b> to <b>8-30-57</b> and last saw him alive on <b>8-30-57</b> Death occurred at <b>6:30</b> P. m. on the date stated above; and to the best of my knowledge, from the causes stated	
22a. SIGNATURE (Degree or title) <b>A. E. Arsl</b>	22b. ADDRESS <b>M. D. VAH, ST. LOUIS, MISSOURI</b>
22c. DATE SIGNED <b>8-31-57</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT 1 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WARE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>WARE MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>MAHN FUNERAL HOME</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 3 '57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

MEDICAL CERTIFICATION

0201

NO. 1000  
1949

**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 *Gerald J. Mohr*  
.....

Licensed Embalmer No. *49*

P. O. Address *Des Moines*

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.