

Health,
& Welfare
S. Public
with Service

S. 300
v. 1-56

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. Securing the medical certification in the specific manner required by 193.140 MoRS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42855
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2858

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>								
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. John 4211</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) <u>St. Louis Co. Hosp.</u>			Length of stay in 1b <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>3437 Charlack</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>TREIBER</u> Last <u>TREIBER</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1957</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-6-1879</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Allegan, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>James Williams</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Wilson</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John Treiber 3437 Charlack</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Unknown</u>		
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. _____ p. m. _____ Month _____ Day _____ Year _____												
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 <u>11-13-57</u> to <u>11-15-57</u> and last saw ^{her} him alive on <u>11-15-57</u> Death occurred at <u>7:30</u> <u>A. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <u>John W. Hilleman</u> (Degree or title)						22b. ADDRESS <u>601 S. Brentwood Clayton, Mo.</u>			22c. DATE SIGNED <u>11/15/57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)						
<u>Burial</u>		<u>11-18-57</u>		<u>Sunset</u>		<u>St. Louis County, Mo.</u>						
24. FUNERAL DIRECTOR <u>Earl Hilleman</u> ADDRESS <u>Overland, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-16-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert B. Dumble MD</u>						

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 *E. H. Hillerman*.....

Licensed Embalmer No. *350*

P. O. Address *Orlando, Fla*

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.