

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46901  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3267

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) OR TOWN <u>RURAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROBERT KOCH HOSP.</u>		Length of stay in <u>156</u> days	d. STREET ADDRESS <u>5005 JAMIESON</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDA</u> Middle <u>FLORIS</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>57</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1899</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months   Day   Hours   Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>BEN SEWELL</u>			14. MOTHER'S MAIDEN NAME <u>SERENA BREUER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>ROBERT KOCH RECORD ROOM, KOCH, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>PULMONARY TUBERCULOSIS</u>					
DUE TO (c) <u>OOBX</u>					
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"/> <u>2</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   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 <u>7-21-56</u> to <u>12-23-57</u> and last saw <u>her</u> alive on <u>12-23-57</u> Death occurred at <u>3:34 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Axel R. Brown, M.D.</u>			22b. ADDRESS <u>Robert Koch Hospital, Koch No.</u>		22c. DATE SIGNED <u>12-24-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Dec. 26, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	
				23d. LOCATION (City, town, or county) <u>Cuba, Missouri</u> (State)	
24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries</u> <u>6464 Chippewa St. Louis, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-24-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombrowski</u> <u>arc</u>

(Licensed Embalmer's Statement on Reverse Side)

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Rice C. Edanson*.....

Licensed Embalmer No. *47*.....

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.