

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2851

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

156

300  
1-57

1. PLACE OF DEATH a. COUNTY			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) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3677a Blaine Ave.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 4038 Lafayette Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM P. DWYER			4. DATE OF DEATH Month Day Year Jan. 7 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1876	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk-Terminal R. R. Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kirkwood, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Dwyer		13b. MOTHER'S MAIDEN NAME Margaret Riley		14. NAME OF HUSBAND OR WIFE Late Fernanda J. Dwyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. 489-01-8349	17. INFORMANT Address Genevieve McLain 3677a Blaine Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Generalized Arteriosclerosis</i>			<i>5 years</i>
		DUE TO (c) <i>Arteriosclerotic Heart Disease</i>			<i>5 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <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 Death occurred at <i>3:30 A. 1958</i> on <i>Jan. 7, 1958</i> and last saw her/him alive on <i>Jan. 5, 1958</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Joseph A. Mueller M.D.</i>			22b. ADDRESS <i>3177 So. GRAND</i>		22c. DATE SIGNED <i>1-7-58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<i>Removal (Mtn)</i>		<i>Jan. 10, 1958</i>	<i>St. Columbkille Cem.</i>		<i>Byrnesville, Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Kriegshauser 4228 S. Kingshighway</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 7 '58</i>		26. REGISTRAR'S SIGNATURE <i>Joseph A. Mueller M.D.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No syndromes can be listed. All diseases in Part I must be causally related.

R 11-11-70

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 *William D. White* .....

Licensed Embalmer No. *4291* .....

P. O. Address *422 S. King St* .....

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.