

health, Welfare public service  
 300  
 1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED JAN 27 1958

3883

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 66

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MANCHESTER</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>COUNTY</u>		Length of stay in 1b <u>10 DAYS</u>	d. STREET ADDRESS <u>BAXTER RD.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILBERT</u> Middle <u>ARNOLD</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</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>SEPT 16 1892</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KELLY CONST. Co.</u>		11. BIRTHPLACE (City and state or country) <u>SALEM COUNTY U.S.A.</u>	
13. FATHER'S NAME <u>JAMES WILLIAMS</u>			14. MOTHER'S MAIDEN NAME <u>ALICE SMITH</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>499-03-3399A</u>		17. INFORMANT <u>Genev Prager Manchester, Mo.</u> Address	
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>Cerebral thrombosis due to arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) _____
					DUE TO (c) _____
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? <u>2</u> 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 _____ 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>12-29-1957</u> to <u>1-7-1958</u> and last saw her/him alive on <u>1-7-1958</u> Death occurred at <u>7:55 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>Angelo Speno M.D.</u>			22b. ADDRESS <u>601 S. BRENTWOOD BLVD.</u>		22c. DATE SIGNED <u>1-7-58</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	23b. DATE <u>1/10/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>CLAYTON, MO.</u>	
24. FUNERAL DIRECTOR <u>Schrader Funeral Home, Ballwin, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>1-8-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert J. Donk MD</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JUN 1 1962

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..... *Richard Bopp*

Licensed Embalmer No. *45*

P. O. Address *Baltimore*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.