

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008119
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 425

| | | | | | |
|--|-------------------------------|---|--|---|--|
| 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>Clayton</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Clayton</u> <u>4442</u> <u>0</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>128 N. Bemiston</u> | | Length of stay in lb <u>years</u> | d. STREET ADDRESS (If outside, give location) <u>128 N. Bemiston</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>RAYBURN</u> Last <u>WILLS</u> | | | 4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1958</u> | | |
| 5. SEX <input checked="" type="checkbox"/> male | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-3-1888</u> | |
| 9. AGE (In years last birthday) <u>69</u> | | 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) <u>accountant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mo-Pac. R.R.</u> | | 11. BIRTHPLACE (City and state or country) <u>Atchison, Kan.</u> | |
| 13a. FATHER'S NAME <u>Ernest C. Wills</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Lorena Duncan</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Miss Nancy Wills - 128 No. Bemiston</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>carcinomatosis, generalized</u> DUE TO (b) <u>adenocarcinoma of recto-sigmoid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>154X</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</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 <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>12-31-56</u> to <u>2-14-58</u> and last saw <u>him</u> alive on <u>2-14-58</u> Death occurred at <u>11: a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Herbert P. Blomberg M.D.</u> | | | 22b. ADDRESS <u>17555. Grand</u> | | 22c. DATE SIGNED <u>2/14/58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>2-17-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton and sons 7233 Delmar</u> | | | 25. DATE RECD. BY LOCAL REG. <u>2-15-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Herbert P. Blomberg</u> |

USE ONLY BLACK INK-OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
P. O. Address *St. Louis, Mo.*

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.

1-23-68