

FILED APR 25 1958

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH  
a. COUNTY Missouri  
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis  
c. LENGTH OF STAY (in this place)  
d. FULL NAME OF HOSPITAL OR INSTITUTION Booth Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)  
a. STATE Missouri b. COUNTY Jefferson  
c. CITY (If outside corporate limits, write RURAL and give township) Arnold  
d. STREET ADDRESS (If rural, give location) R. R. 3 Box 14

3. NAME OF DECEASED (Type or Print)  
a. (First) Jill b. (Middle) c. (Last) Filey  
4. DATE OF DEATH (Month) 4 (Day) 18 (Year) 58

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0  
8. DATE OF BIRTH 4-18-58 9. AGE (In years last birthday) 0 10. IF UNDER 1 YEAR Days 0 11. IF UNDER 24 HRS. Hours Min. 0 12.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) St. Louis, Mo 0 12. CITIZENRY OF WHAT COUNTRY? USA

13a. FATHER'S NAME Willard James Filer 13b. MOTHER'S MAIDEN NAME Geneva Irene Harris 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Geneva J. Filer Arnold, Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Congenital atelectasis  
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) Gestation 28 weeks  
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 762.5 20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <sup>Jan</sup> Apr 18, 1958, to Apr 18, 1958, that I last saw the deceased alive on April 18, 1958, and that death occurred at 1:50 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Leroy E. Ellison M.D. 0 23b. ADDRESS 3610 So Broadway 23c. DATE SIGNED Apr 18, 1958

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 4-18-58 24c. NAME OF CEMETERY OR CREMATORY 24d. LOCATION (City, town, or county) (State) Fredericktown, Mo.

DATE RECD BY LOCAL REG. APR 18 1958 REGISTRAR'S SIGNATURE (Carl Smith M.D. Napin & Name, Fredericktown, Mo.) 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 \_\_\_\_\_

working under my personal supervision.

*Not embalmed*  
Student Embalmer No. ....

Signed *Willard J. Filer*  
.....

Signed.....  
Student Embalmer

Licensed Embalmer No. ....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.