

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006837  
STATE FILE NUMBER

REGISTRATION DISTRICT NO. 316 PRIMARY REGISTRATION DISTRICT NO. 6074 REGISTRAR'S NO. 62

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Desloge</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Desloge</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		Length of stay in lb <u>09 1/2</u>	d. STREET ADDRESS (If outside, give location) <u>09 1/2</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>SOLDIN</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1959</u>		
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5. SEX <u>Male c</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>Dec 14, 1897</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Clerk</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	11. BIRTHPLACE (City and state or country) <u>Racine, Wis.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Berthold Soldin</u>	13b. MOTHER'S MAIDEN NAME <u>Cora Ida Hensely</u>	14. NAME OF HUSBAND OR WIFE <u>Ruth Rongey Soldin</u>
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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>498-09-1053</u>	17. INFORMANT <u>Mrs. Ruth Soldin Desloge, Mo.</u>	Address
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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>Bronchio genic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. 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) <u>1621</u>		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.) <u>1621</u>
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from <u>Oct 1958</u> to <u>Feb 15, 1959</u> and last saw <sup>her</sup> him alive on <u>Feb 15, 1959</u> Death occurred at <u>3:21</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. L. Foster</u> (Degree or title) <u>MS</u>	22b. ADDRESS <u>Desloge, Missouri</u>	22c. DATE SIGNED <u>2-17-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb-18-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Memo</u>	23d. LOCATION (City, town, or county) (State) <u>St. Francois Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Murphy L. Sparks</u>	ADDRESS <u>Flat River, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb 17, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Gather Rudloff</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

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

FEB 26 1959

JUN 17 1959

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 *Minneapolis L. Sp...* .....

Licensed Embalmer No. *4336* .....  
P. O. Address *First Avenue, Minn.* .....

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.