

Health  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015966  
STATE FILE NUMBER  
2 4380

FILED MAY 14 1959  
SL 19751

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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-57  
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WARREN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N.GRAND, ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>WARRENTON</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET.ADM. HOSPITAL</b>		Length of stay in 1b <b>13 days</b>	d. STREET ADDRESS (If outside, give location) <b>ROUTE # 2</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>WILLIAMS</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>3</b> Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/73</b>
9. AGE (In years) <b>85</b>	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) <b>CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Timber</b>	11. BIRTHPLACE (City and state or country) <b>WELLS CO., INDIANA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>JOHN WILLIAMS</b>	13b. MOTHER'S MAIDEN NAME <b>VIRETTA EWELL</b>
14. NAME OF HUSBAND OR WIFE <b>EDITH WILLIAMS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <b>YES SPAW</b>	16. SOCIAL SECURITY NO. <b>None</b>
17. INFORMANT <b>VA HOSP. RECORDS, ST. LOUIS, MO.</b>		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) <b>GASTRO INTESTINAL BLEEDING</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>DUODENAL ULCER PERFORATING INTO PANCREAS</b>			YEARS
DUE TO (c) <b>571.1</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHO PNEUMONIA- POST OPERATIVE. INTESTINAL OBSTRUCTION</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>4/20/59</b> to <b>5/3/59</b> and last saw him alive on <b>5/3/59</b> Death occurred at <b>12:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>G. G. Williams</i> M.D.		22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>	22c. DATE SIGNED <b>5/3/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>13-5-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>
23d. LOCATION (City, town, or county) <b>Warrenton, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>F.W.Nieburg, &amp; Co., Warrenton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 4 '59</b>	26. REGISTRAR'S SIGNATURE <i>Neal Smith M.D.</i>

(Licensed Embalmer's Statement on Reverse Side)

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 *Lawrence D. Gering* .....

Licensed Embalmer No. *4979* .....

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.