

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013308

FILED VS MAR 24 1960

2 2672

STATE FILE NUMBER

INDEXED

Registration District No. Primary Registration District No. Registrar's

1. PLACE OF DEATH a. COUNTY Deaconess Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN st. Louis Mo.		Length of stay in 1b 10 days		c. CITY OR TOWN Gerald		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.R.#1		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Paul Tillmann				4. DATE OF DEATH Month Day Year March 6 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1877	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Loosecreek, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Frank Tillmann			13b. MOTHER'S MAIDEN NAME Elizabeth H. Hoerscher		14. NAME OF HUSBAND OR WIFE Mary V. Tillmann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. None	17. INFORMANT Address Elizabeth Tillmann				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) 420.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 11 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostatic hyperplasia with bladder neck obstruction					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour Month, Day, Year s.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 2-25-60 to 3-6-60 and last saw her alive on 3-6-60 Death occurred at 12:20 p. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) E. E. Mueller M.D.				22b. ADDRESS 634 N. Grand Blvd.		22c. DATE SIGNED 3/7/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-9-1960	23c. NAME OF CEMETERY OR CREMATORY Holy Family		23d. LOCATION (City, town, or county) (State) New Haven, Mo. Ru #1				
24. FUNERAL DIRECTOR B. J. Meyer Gerald, Mo.			25. DATE RECD. BY LOCAL REG. MAR 7 1960		26. REGISTRAR'S SIGNATURE Loan Smith M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

KS MAR 30 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley E. Meyer

Licensed Embalmer No. 4639

P. O. Address Union, N

*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.