

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-011786
STATE FILE NUMBER

318 Primary Registration District No. 1003 Registrar's No. 2639

AMENDED

Registration District No. 318
FILED MAR 30 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Ladue	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes hospital		d. STREET ADDRESS (If outside, give location) 20 Brae Burn Dr.	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last William P. Williams			4. DATE OF DEATH Month Day Year March 19, 1961		
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 4-11-1920	9. AGE (last birthday) 40	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales T.W.A.		10b. KIND OF BUSINESS OR INDUSTRY Sales Manager	11. BIRTHPLACE (City and state or country) Princeton. KY.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James H. Williams		13b. MOTHER'S MAIDEN NAME Mary Powell		14. NAME OF HUSBAND OR WIFE Marjorie C. Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. W.G.W. 2		17. INFORMANT Address Mrs. Marjorie C. Williams (above)	

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>Thrombosis middle cerebral artery RT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
DUE TO (b) <u>Arteriosclerosis, severe, int. carotid artery RT</u>			<u>unknown</u>
DUE TO (c) <u>occlusion, int. carotid artery - RT</u>			<u>8 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia bilat. Bronchial, terminal</u>			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		
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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.)	
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		
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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
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21. I attended the deceased from 3-12-61 to 3-19-61 and last saw him alive on 3-18-61
Death occurred at 8:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George E. Rouehen</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>3720 Weeping Fern Ave St Louis 8</u>	22c. DATE SIGNED <u>3-19-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>March 21, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>
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24. FUNERAL DIRECTOR <u>C.P.R. Lupton and Sons 7233 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 20 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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.