

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012183

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 911

AMENDED FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch Mo</u>		Length of stay in 1b <u>20 days</u>	c. CITY OR TOWN <u>ST LOUIS</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 <u>ROBT KOCH HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2110 2 So 9th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>WILLIAMS</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>APR</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Male</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>7-14-96</u>	9. AGE (last birthday) <u>64</u>	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) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>ALTON Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>ROBERT WILLIAMS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY SISK</u>		14. NAME OF HUSBAND OR WIFE <u>ROSIE RICE</u>		
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>NO</u>	17. INFORMANT Address <u>Hospital Record Robt Koch Hospital</u>			
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>HEART FAILURE</u> DUE TO (b) <u>LUNG ABSCESS - LEFT LOWER LOBE</u> DUE TO (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260X</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					INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year						
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 <u>3-14-61</u> to <u>4-2-61</u> and last saw him alive on <u>4-1-61</u> Death occurred at <u>5:10 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Frank Cohen</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Robert Koch Hosp Koch Mo</u>		22c. DATE SIGNED <u>4-2-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-3-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>W.O.W. Cemetery</u>		23d. LOCATION (City, town, or county) <u>East Prairie, Missouri</u>	(State)	
24. FUNERAL DIRECTOR ADDRESS <u>C. Hoffmeister Mortuaries 7814 S. Broadway</u>		25. DATE RECD. BY LOCAL REG. <u>4-3-61</u>	26. REGISTRAR'S SIGNATURE <u>J. M. M. M. M. M.</u>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

4-10-10-10-

MAY 18 1961

APR 14 1961

**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 T. Davis Shelby Jr.

Licensed Embalmer No. 4940  
P. O. Address East Point

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.