

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046426

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11998**

FILED JAN 5 1962

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location): HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 1636 FRANKLIN	

3. NAME OF DECEASED (Type or print) WILLIAM First HOLT Middle Last	4. DATE OF DEATH Month DEC. Day 20, Year 1961
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1893	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ODD JOBS	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE NONE
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT ANTHERY HINES 1636 FRANKLIN 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) Multiple myeloma		INTERVAL BETWEEN ONSET AND DEATH
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) Canceroma of Stomach		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 12/20/61	COUNTY 12/20/61	STATE
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21. I attended the deceased from **11/1/61** to **12/20/61** and last saw her him alive on **12/20/61**
Death occurred at **8:45A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE RO Cole M.D. (Degree or title)	22b. ADDRESS 1515 LAFAYETTE	22c. DATE SIGNED 12/20/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-22-61	23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON	23d. LOCATION (City, town, or county) (State) KIRKWOOD MO.
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24. FUNERAL DIRECTOR P. WATKINS 2700 THOMAS ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 22 1961	26. REGISTRAR'S SIGNATURE Road Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOT EMBALMED

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

P. Watkins

Licensed Embalmer No. _____

P. O. Address _____

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.