

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED JAN 5 1967

-61-047013

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12209

STATE FILE NUMBER

AMENDED

| | | | | | | | |
|--|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 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 TOWNSHIP <u>ST. LOUIS, MO.</u> | | Length of stay in 1b <u>10 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>ST. LOUIS CITY HOSP. #1</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>8520 So. Broadway</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>IVY</u> Middle <u>WILLIS</u> Last | | | 4. DATE OF DEATH Month <u>DEC.</u> Day <u>26.</u> Year <u>1961</u> | | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jan 6 1905</u> | 9. AGE (last birthday) <u>56</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Promptior</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Confectionary</u> | | 11. BIRTHPLACE (City and state or country) <u>Tennessee</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>Newt Hoggard</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Ola Brice</u> | | 14. NAME OF HUSBAND OR WIFE <u>Thomas</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. | | 17. INFORMANT Address <u>Carl Vail 619 Dennison Dr Ballwin Mo</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>Liver failure</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>583x</u> | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 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 | | |
| 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 <u>2:30</u> a.m. p.m. | Month, Day, Year <u>12/16/61</u> | | | | | | |
| 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>12/16/61</u> to <u>12/26/61</u> and last saw her/him alive on <u>12/26/61</u> Death occurred at <u>2:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>ER Schultz MD</u> | | | | 22b. ADDRESS <u>1515 LAFAYETTE AVE</u> | | | 22c. DATE SIGNED <u>12/26/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>Dec 29 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>1800 Lemay Ferry Rd.</u> | | |
| 24. FUNERAL DIRECTOR <u>Hoffmeister 7814 So Broadway</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>DEC 28 1961</u> | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> | |

DOCUMENT

MEDICAL CERTIFICATION

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 Louis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.