

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-004755

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

1118

STATE FILE NUMBER

AMENDED

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

FILED FEB 2 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE Mo.	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
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 6730 West Park Ave.		d. STREET ADDRESS (If outside, give location) 6730 West Park Ave.	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First CLARA	Middle M.	Last WILLMORE	4. DATE OF DEATH	Month Jan.	Day 24	Year 1962
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1866	9. AGE (last birthday) 95	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months		Days
				Hours		Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	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 Charles Gerling	13b. MOTHER'S MAIDEN NAME Mary Otto	14. NAME OF HUSBAND OR WIFE Late William E. Willmore
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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 Clara Watts 6730 West Park Ave.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS		10 MYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) GENERALIZED ARTERIOSCLEROSIS	20 YRS
	DUE TO (c) 332X	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MARRIED SENILITY. BLINDNESS.	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	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
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21. I attended the deceased from 8:30 P. 1958 to Jan 24, 1962 and last saw her alive on JAN 21, 1962
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Johna Curran, MD	(Degree or title)	22b. ADDRESS 4401 HANLTON - ST. LOUIS 9, MO	22c. DATE SIGNED 1-25-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 27, 1962	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 25 1962	26. REGISTRAR'S SIGNATURE Loal Smith M.D.
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

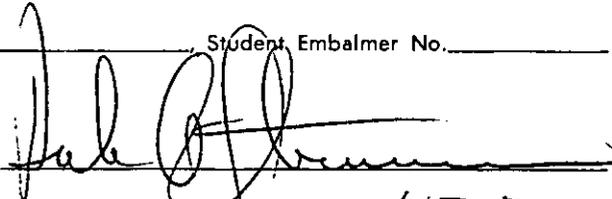
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4533

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.