

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9548 - 62-036881  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED OCT 11 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1  
2 *2/28*  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>e. STATE <b>Missouri</b> COUNTY                                    |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Mo.</b>  |   | Length of stay in 1b  | c. CITY OR TOWN <b>St. Louis.</b>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Bethesda Hospital</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>303 N. Union, Blvd.</b> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Lillie</b> Middle <b>D.</b> Last <b>Williams</b>   |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>4</b> Year <b>1962</b>      |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/12/1881</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>   | 9. AGE (last birthday)<br><b>81</b>   |
| 13a. FATHER'S NAME<br><b>Amos Dennis</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Hart</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Cairo, Illinois.</b>       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No. Nil.</b>  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>  |   | 17. INFORMANT<br><b>Catherine Droll,</b> Address <b>303 N. Union, Blvd.</b>   |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Generalized Arteriosclerosis</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months.</b>  |   |
| DUE TO (c) <b>Arteriosclerotic H. Disease</b>   |   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>4200</b>            |   |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown   |   |   |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>July 1954</b> to <b>Oct. 4 1962</b> and last saw her alive on <b>Oct 4-1962</b><br>Death occurred at <b>12:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Walter B. Bawel M.D.</b>   |   | 22b. ADDRESS<br><b>4660 Mayfield</b>  | 22c. DATE SIGNED<br><b>10/5/62</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>10-4-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Cairo, Illinois.</b>    |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>   |   | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 5 1962</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Loan Smith, M.D.</b>                        |

**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

*Stanley A. Dixon*

Licensed Embalmer No. 4193

P. O. Address J. D.

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.