

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10833**
Registrar's No. **2403**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY MO.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (in this place) 0		d. STREET ADDRESS (If rural, give location) 1440 PAPPIN	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) Ronald Williams			4. DATE OF DEATH (Month) (Day) (Year) March 13 1949		
5. SEX MALE COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0		8. DATE OF BIRTH AUG. 7, 1947	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 1 7	
				11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.	
13a. FATHER'S NAME JOSEPH WILLIAMS		13b. MOTHER'S MAIDEN NAME MARY DUKES		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT'S SIGNATURE OR NAME JOSEPH WILLIAMS	
				ADDRESS 1440 PAPPIN	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia; T. B. Meningitis		INTERVAL BETWEEN ONSET AND DEATH Undet.	
		ANTECEDENT CAUSES DUE TO (b) Undetermined			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3-7**, 19**49**, to **3-13**, 19**49**, that I last saw the deceased alive on **3-13**, 1949, and that death occurred at **7:20 P m.**, from the causes and on the date stated above.

23a. SIGNATURE Helen E. Nash		(Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 3-14-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE MAR. 17, 1949		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR 16 1949		25. FUNERAL DIRECTOR'S SIGNATURE Wloyd English		ADDRESS 2931 LUCAS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Burleson English*

Licensed Embalmer No. *4208*

P. O. Address *2931 LUCAS*

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 this body is not embalmed, fact should be so stated above.