

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6246

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		c. CITY (If outside corporate limits, write RURAL and give township) Troy	
		d. STREET ADDRESS N. R.	

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth	b. (Middle) E.	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) July 15 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Oct. 20, 1886	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Troy, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Troy, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME James W. Brown	13b. MOTHER'S MAIDEN NAME Susan Owens	14. NAME OF HUSBAND OR WIFE Benjamin Williams
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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'S SIGNATURE OR NAME Earl Williams, Troy, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION no operation	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 930
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200
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22. I hereby certify that I attended the deceased from July 7, 1949, to July 15, 1949, that I last saw the deceased alive on July 15, 1949, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE Jm. W. Norton, M.D.	(Degree or title)	23b. ADDRESS 634 No. Grand - St. Louis, Mo.	23c. DATE SIGNED 7-18-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-16-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Wright City, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J. B. Savater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

J. W. Pembrey

Licensed Embalmer No. *3653*

P. O. Address *77 Fair St*

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.