

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 1949

State File No. \_\_\_\_\_  
Registrar's No. **8225**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

|  |  |  |  |  |  |  |  |
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| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>  |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>8225</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )  |  | c. LENGTH OF STAY (In this place) <b>17</b>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>                                      |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>   |  |  |  | d. STREET ADDRESS (If rural, give location) <b>21 1843 O Fallon Street</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>Isabella</b>   |  | b. (Middle) _____  |  | c. (Last) <b>Williams</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 20 1949</b>                       |  |
| 5. SEX <b>female</b>   |  | 6. COLOR OR RACE <b>col</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>  |  | 8. DATE OF BIRTH <b>Dec 23 1881</b>  |  |
| 9. AGE (In years last birthday) <b>67</b>  |  | IF UNDER 1 YEAR Months <b>8</b> Days <b>27</b>   |  | IF UNDER 4 HRS. Hours <b>1</b> Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (State or foreign country) <b>Yazoo County Mississippi</b>  |  | 12. CITIZEN OF WHAT COUNTRY? _____   |  |
| 13a. FATHER'S NAME <b>Thomas Bass</b>  |  |  | 13b. MOTHER'S MAIDEN NAME <b>Lacy Meyers</b> |  |  | 14. NAME OF HUSBAND OR WIFE _____  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____  |  | 16. SOCIAL SECURITY NO. <b>no</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>William Shelby 1843 O Fallon St</b>   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) _____   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>                                   |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Undetermined</b> |  |  |  |  |  |
|  |  | DUE TO (c) _____   |  |  |  |  |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>      |  |  |  |  |  |
| 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) <b>82</b>  |  |  |  |
| 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? <b>3 2 2 X</b>  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>9-15</b> , 19 <b>49</b> , to <b>9-20</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>9-20</b> , 19 <b>49</b> , and that death occurred at <b>3 a</b> m., from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>James H. Hedrick D.</b>  |  |  |  | 23b. ADDRESS <b>2601 N Whittier St</b>   |  | 23c. DATE SIGNED <b>9-20-49</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____  |  | 24b. DATE <b>9-26-1949</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Co. Mo</b>           |  |
| DATE REC'D BY LOCAL REG. <b>SEP. 23 1949</b>   |  | REGISTRAR'S SIGNATURE <b>J. B. Lester</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. H. Randle &amp; Son 3133 Bell Ave</b>   |  |  |  |

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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

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.