

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22144

State File No. 5496

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	
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 2178	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 2609 So. Grand		d. STREET ADDRESS (If rural, give location) 17 2609 So. Grand	

3. NAME OF DECEASED (Type or Print)	a. (First) Emma	b. (Middle) Jane	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) June 22, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Sept. 12, 1857	9. AGE (In years last birthday) 92 # UNDER 1 YEAR Months # UNDER 1 MTH. Hours Mth.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Henry Gardner Williams	13b. MOTHER'S MAIDEN NAME Cyntharilla Unknown	14. NAME OF HUSBAND OR WIFE None
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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. 489-07-7500	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lucy M. Eynck	ADDRESS 4911 Washington Blvd
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Congenital heart failure - (myocardial) damage!</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arteriosclerosis - Hypertension many yrs</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Cerebral Hemorrhage</i>		DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 442X
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22. I hereby certify that I attended the deceased from June 15, 1950, to June 20, 1950, that I last saw the deceased alive on June 20, 1950, and that death occurred at 5 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frances R. Pitocil M.D. - U	23b. ADDRESS 5233 Watsonway	23c. DATE SIGNED 6-23-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-24-50	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 24 1950	REGISTRAR'S SIGNATURE J. B. Lanter	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Hand

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

working under my personal supervision.

Student Embalmer No.

Signed

William A. Satter

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address A. C. Co. 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.