

FILED AUG 11 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25420

State File No. ....

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6417

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6417	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Louis			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) 445 OR TOWN <del>St Louis</del>			
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital				STREET ADDRESS (If rural, give location) # 2 SCHRIER Lane <del>4453</del> Jackson Clayton Mo			
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) Adams		c. (Last) Williams	
4. DATE OF DEATH		(Month) 7		(Day) 26		(Year) 50	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 2-11-1881		9. AGE (In years last birthday) 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pickering Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Bue Williams		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Ella			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Iloyd Williams			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fr of skull; Subdural hemorrhage suffered when deceased fell down concrete steps leading to the basement at home of Mrs Lorraine Longlet 4255 Hight Ave on or about July 21 1950 exact time unknown II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. unknown				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 000 Accident				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) St Louis		21d. (COUNTY) Mo (STATE)	
21e. TIME OF INJURY July 21 50		(Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E 9000	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:04 p.m., from the causes and on the date stated above.							
23. SIGNATURE Patrick E Taylor Cor (Degree or title)				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 7-21-50	
24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		24b. DATE 7-24-50		24c. NAME OF CEMETERY OR CREMATORY Mt Hope		24d. LOCATION (City, town, or county) (State) Mt Hope St Louis Mo	
DATE REC'D BY LOCAL REG. 7-27-50		REGISTRAR'S SIGNATURE J. B Foster		25. FUNERAL DIRECTOR'S NAME AND ADDRESS 4104 Manchester Ave. St. Louis 10, Mo			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 *Howard J. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *OT Paris 10, Mo*

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.