

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **31965**

FILED OCT 10 1951

Registrar's No. **8386**

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	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION Irmin Desloge Hospital		d. STREET ADDRESS (If rural, give location) 23 2500 S. 18th Street	
3. NAME OF DECEASED (Type or Print) a. (First) Marietta		b. (Middle)	
c. (Last) Williamson		4. DATE OF DEATH (Month) (Day) (Year) 9-20-51	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 11-18-1862
9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Cullen	
13b. MOTHER'S MAIDEN NAME Mary Ann Sheehan		14. NAME OF HUSBAND OR WIFE Marshall Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Phillip C. Brown		ADDRESS 5604 Rhodes	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Thrombosis INTERVAL BETWEEN ONSET AND DEATH 10 days ANTECEDENT CAUSES DUE TO (b) Cerebral arteriosclerosis 10 yrs DUE TO (c) 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	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 334X		22. I hereby certify that I attended the deceased from 9-12-51 19 51 , to 9-20-51 , 19 51 , that I last saw the deceased alive on 9-20-51 , 19 51 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.	
23a. SIGNATURE John F. Kestner, M.D.		23b. ADDRESS 1325 S. Grand, St. Louis 4, Mo.	
23c. DATE SIGNED 9-21-51		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 9-24-51		24c. NAME OF CEMETERY OR CREMATORY Hiram Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Carl Smith M.D. Ziegenhein Bros 6409 Gravois	
DATE REC'D BY LOCAL REG. SEP 21 1951		25. FUNERAL DIRECTOR'S ADDRESS 6409 Gravois	

WRITE PLAINLY—USING UNFADEING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John M. Simpson

Signed.....
Student Embalmer

Licensed Embalmer No. *4343*

P. O. Address *St. Louis, 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.