

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35759

State File No. 9017

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ 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 town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION HomerrG Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2229 2823 Walnut	

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Wright c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) Oct. 9 1951		
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2	8. DATE OF BIRTH 2-11-1896	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Arkansas /	

12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Harrison Holt		13b. MOTHER'S MAIDEN NAME Emma ??		14. NAME OF HUSBAND OR WIFE George Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Magnoliz Morgan, 2823 Walnut St			

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES DUE TO (b) Hypertensive Heart Disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH 7 days Undet.	
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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., to or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
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"/>		21h. HOW DID INJURY OCCUR? H43X			

22. I hereby certify that I attended the deceased from 10-4, 1951, to 10-9, 1951, that I last saw the deceased alive on 10-9, 1951, and that death occurred at 4:55 p. m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Lorenzo W. Harris M. D.		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 10-11-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Oct 15/51		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem		24d. LOCATION (City, town, or county) (State) St. Louis MO	
DATE REC'D BY LOCAL REG. OCT 13 1951		REGISTRAR'S SIGNATURE E. J. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. G. Green 4214 Delmar			

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

F. A. Green

Licensed Embalmer No.

2963

P. O. Address

4214 Delmar

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.