

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35766**
9446

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 526 Leeton St.	

3. NAME OF DECEASED (Type or Print) a. (First) Sim	b. (Middle) Willis	c. (Last) Willis	4. DATE OF DEATH (Month) (Day) (Year) 10 22 51
---	------------------------------	----------------------------	--

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-5-1905	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 17
-----------------------	------------------------------------	--	-------------------------------------	--	---------------------------------------	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Rock Island R. R.	11. BIRTHPLACE (State or foreign country) Georgia	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME Benjamin Willis	13b. MOTHER'S MAIDEN NAME Etta Thomas	14. NAME OF HUSBAND OR WIFE Josephine Willis
--	---	--

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. 708-14-2840	17. INFORMANT'S SIGNATURE OR NAME Josephine Willis	ADDRESS 526 Leeton 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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) illc tuberculosis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) acute myocarditis		
	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 none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---------------------------------------	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Missouri
---	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? none	21g. 5:30
--	---	---	------------------

22. I hereby certify that I attended the deceased from **10 5 1951**, to **10 23 1951**, that I last saw the deceased alive on **10 22 1951**, and that death occurred at **10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. H. Hamann M.D.	23b. ADDRESS 2739 N. Grand	23c. DATE SIGNED 10/23/51
--	--------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-26-51	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Missouri
---	------------------------------	---	---

DATE REC'D BY LOCAL REG. OCT 2 1951	REGISTRAR'S SIGNATURE J. Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Ellis Funeral Home, Inc.	ADDRESS 2820 Stoddard St.
---	---	---	-------------------------------------

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 Fulton E. Culkin

Licensed Embalmer No. 498

P. O. Address Stennis 13.7

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.