

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 14 1952

State File No. 27777
0607

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 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2025 Eugenia st	

3. NAME OF DECEASED (Type or Print) Willie	a. (First)	b. (Middle)	c. (Last) Fields	4. DATE OF DEATH Jan. 17 1952	(Month) (Day) (Year)
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5. SEX M	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MRS. Hours	Mins.
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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) Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Mattie Fields
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes	16. SOCIAL SECURITY NO. Worlds War I-498-10-7099	17. INFORMANT'S SIGNATURE OR NAME Mattie Fields	ADDRESS 2025 Eugenia st
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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) Arteriosclerotic Gangrene both lower limbs (legs and feet)		Undet.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Old Cerebral Vascular disease			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4:50 PM
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22. I hereby certify that I attended the deceased from 1-16, 1952, to 1-17, 1952, that I last saw the deceased alive on 1-17, 1952, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) Wm. G. Reid M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 1-19-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan 22-52	24c. NAME OF CEMETERY OR CREMATORY National Cem	24d. LOCATION (City, town, or county) (State) St Louis Co Mo.
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DATE REC'D BY LOCAL REG. JAN 21 1952	REGISTRAR'S SIGNATURE Earl Smith M. D.	25. FUNERAL DIRECTOR'S SIGNATURE J. W. Hughes	ADDRESS 2620 Lawton blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

EXHIBIT

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 James A. Carter

Licensed Embalmer No. 4681

P. O. Address 4923 Suburban

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.