

FILED FEB 2 1952

STANDARD CERTIFICATE OF DEATH

3464  
 State File No. 0535  
 Registrar's No.

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 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 2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4222a W. Ashland	

3. NAME OF DECEASED (Type or Print) a. (First) Corndores b. (Middle) c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) Jan. 15 1952		
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 4, 1894	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Samuel Williams	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Beulah Williams
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. None	17. INFORMANT'S SIGNATURE OR NAME Marion Williams
		ADDRESS 4222a W. Ashland

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		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Right Hemiplegia		
	ANTECEDENT CAUSES DUE TO (b) Cerebral Thrombosis DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis		Undet. "	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 3322X

22. I hereby certify that I attended the deceased from 12-7, 19 51 to 1-15, 19 52, that I last saw the deceased alive on 1-15, 1952 and that death occurred at 6 a m., from the causes and on the date stated above.

23a. SIGNATURE Lawrence W Harris M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 1-16-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-19-52	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis County		25. FUNERAL DIRECTOR'S SIGNATURE C. P. Boone
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 18 1952	25. FUNERAL DIRECTOR'S SIGNATURE C. P. Boone	ADDRESS 1221 N. Grand

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

Certificate of Informant - add

FILE NO.

DATE

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 James [Signature]

Signed .....  
Student Embalmer

Licensed Embalmer No. 1755

P. O. Address (22) 1st [Signature]

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.