

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18705

State File No.

JUN 6 1952

318

REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No. 4693

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		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219		d. STREET ADDRESS (If rural, give location) 21 3547a Laclede Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Rolla b. (Middle) Williams c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) May 17, 1952	
5. SEX Male		6. COLOR OR RACE Col	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 19, 1898	
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Costodian	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Jefferson City, Mo	
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Lula 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.	
17. INFORMANT'S SIGNATURE OR NAME Lula Williams, 3547a Laclede Ave.		ADDRESS	
19. 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Undetermined</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>External Hemorrhoids</u>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 443X			
22. I hereby certify that I attended the deceased from <u>3-23</u> , 19 <u>52</u> , to <u>5-17</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>52</u> , and that death occurred at <u>7:30a</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <i>Laura Williams</i> M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 5-19-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/22/52	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo	
DATE REC'D BY LOCAL REG. MAY 21 1952		REGISTRAR'S SIGNATURE <i>Carl Smith</i> MO	
25. FUNERAL DIRECTOR'S SIGNATURE R. M. C. Green, 3517 Laclede Avenue		ADDRESS	

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

Melvin E. Green

Licensed Embalmer No. 4428

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.