

FILED JUL 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26491**
Registrar's No. **6319**

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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		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) 11 2517 9 Cora	

3. NAME OF DECEASED (Type or Print) Lillian Williams			4. DATE OF DEATH (Month) (Day) (Year) June 28 1952		
a. (First)		b. (Middle)		c. (Last)	

5. SEX F 3	6. COLOR OR RACE col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH Aug 8, 1883	9. AGE (In years last birthday) 68	10 UNDER 1 YEAR Months	10 UNDER 1 YEAR Days	10 UNDER 1 YEAR Hours	10 UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Miss!	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hospital Record	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Hypertensive Cardiovascular Disease	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
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This does not measure the mode of dying, such as heart failure, asthma, etc. It means the dist. case, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hypertensive Cardiovascular Disease		DUE TO (b) Undetermined
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Heat Exhaustion		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 443X
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22. I hereby certify that I attended the deceased from **5-6**, 19 **52**, to **6-28**, 19 **52**, that I last saw the deceased alive on **6-28**, 19 **52**, and that death occurred at **6:35p** m., from the causes and on the date stated above.

23a. SIGNATURE Edna E. Brooks (Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 7-1-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE July 3/52	24c. NAME OF CEMETERY OR CREMATORY Father-Dickson Cem	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. JUL 2 1952	REGISTRAR'S SIGNATURE Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE F. G. Green	ADDRESS 4214 Delmar
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

F. A. Green

Signed:
Student Embalmer

Licensed Embalmer No. *9963*

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.