

FILED SEP 5 1952 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2649

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2119					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		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 4364 St. Louis Avenue				
3. NAME OF DECEASED (Type or Print) a. (First) Williams #1 b. (Middle)			4. DATE OF DEATH (Month) (Day) (Year) 7 25 52				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			
8. DATE OF BIRTH 7-24-52		9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Days 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) 9			
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Elizabeth Walls			
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT'S SIGNATURE OR NAME Father M. Howard		ADDRESS R.R.L. 2601 N. Whittier					
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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? 776x			
22. I hereby certify that I attended the deceased from 7-24-52, 1952, to 7-25, 1952, that I last saw the deceased alive on 7-25, 1952 and that death occurred at 10:50 PM, from the causes and on the date stated above.							
22a. SIGNATURE William H. Seukler M.D.				22b. ADDRESS 2601 N. Whittier		22c. DATE SIGNED 7-31-52	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-30-54		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. AUG 12 1952		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service			

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.