

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33575**
Registrar's No. **8925**

FILED OCT 4 1952

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PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8925		
1. PLACE OF DEATH a. COUNTY St. Louis Mo				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		d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION 3021 Vine Grove		e. STREET ADDRESS 10		f. FULL NAME OF HOSPITAL OR INSTITUTION 3021 Vine Grove		g. STREET ADDRESS 8		
3. NAME OF DECEASED (Type or Print) a. (First) Daisy			b. (Middle) _____			c. (Last) William		
4. DATE OF DEATH (Month) (Day) (Year) September 22/52		5. SEX Female		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		
8. DATE OF BIRTH April 22, 1886		9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Miss		
12. CITIZEN OF WHAT COUNTRY? Yes		13a. FATHER'S NAME Jose Turner		13b. MOTHER'S MAIDEN NAME Emmalne Legrone		14. NAME OF HUSBAND OR WIFE Jim William		
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. No		17. INFORMANT'S SIGNATURE OR NAME Mr Jim William				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkin's Disease				
II. 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 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)		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 203 X						
22. I hereby certify that I attended the deceased from Jan 18, 1952 , to Sept 22, 1952 , that I last saw the deceased alive on Sept 21, 1952 , and that death occurred at 6 A. m. , from the causes and on the date stated above.								
23a. SIGNATURE J. Jones M.D.				23b. ADDRESS 2330 Franklin Ave		23c. DATE SIGNED 9/23/52		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9/26/52		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. SEP 25 1952				REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Herman J. Smith		
				ADDRESS 4247/w Labadie Ave				

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.....
Student Embalmer

Signed *Lawrence C. Mackson*

Licensed Embalmer No. *4341*

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.