

FILED OCT 8 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33589
Registrar's No. 8777

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 death) a. STATE Missouri b. COUNTY St. Louis	
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 University City 4326	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If rural, give location) 6931 Amherst Avenue	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) CHESTER	b. (Middle) HUBBARD	c. (Last) WILLIAMSON, Jr	9	18	52
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 14, 1892		
9. AGE (In years last birthday) 60		10. KIND OF BUSINESS OR INDUSTRY mill feed merchandiser		11. BIRTHPLACE (State or foreign country) Louisa, Kentucky	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Chester Hubbard Williamson, Sr.		

13b. MOTHER'S MAIDEN NAME Thurza Burns		14. NAME OF HUSBAND OR WIFE Katharine Jeffris Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW #1		16. SOCIAL SECURITY NO. W.W. #1	
17. INFORMANT'S SIGNATURE OR NAME Katharine Williamson		17. ADDRESS 6931 Amherst Avenue	

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) Cerebral vascular thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) general arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 10 hours ? years	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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? 332'x	

22. I hereby certify that I attended the deceased from Dec 19, 1947, to April 18, 1952, that I last saw the deceased alive on Sept 18, 1952, and that death occurred at 4 p. m., from the causes and on the date stated above.

23a. SIGNATURE Samuel B Grant M.D.		23b. ADDRESS 114 N Taylor Ave		23c. DATE SIGNED 9/19/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-20-52		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,			

DATE REC'D BY LOCAL REG. SEP 19 1952 REGISTRAR'S SIGNATURE (Licensed Embalmer's Statement on Reverse Side)

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

Dr. Sam Grant
111 N. Taylor
JE-3600

1 to 5

4/11/50

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 Arnold W. Schoene

Signed.....
Student Embalmer

Licensed Embalmer No. 3864

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.