No. 300
10-48

FILED FEB 11 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3941

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1189

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1319a N. Garrison Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2219
d. STREET ADDRESS (If rural, give location): 1319a N. Garrison Ave. 21

3. NAME OF DECEASED (Type or Print)
a. (First): GREEN
b. (Middle):
c. (Last): WILLIAMS

4. DATE OF DEATH (Month) 1 (Day) 28 (Year) 53

5. SEX: male 2
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-10-'84
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): car cleaner (ret.)
10b. KIND OF BUSINESS OR INDUSTRY: T.R.R.A.
11. BIRTHPLACE (City and State or Foreign Country): Decatur, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Easter Williams

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 ADDRESS: Easter Williams 1319a N.Garrison Ave.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension Cardio-Vascular Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 443X

22. *I hereby certify that I attended the deceased from* 1/18, 1953, *to* 1/28, 1953 *that I last saw the deceased alive on* 1/28, 1953 *and that death occurred at* 6:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]
23b. ADDRESS: 3131 Chouteau
23c. DATE SIGNED: 1/31/53

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: 2-2-53
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: FEB 2 1953
REGISTRAR'S SIGNATURE: J. Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Russell Und., Co. 2732 Pine Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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 James A. Carlin

Licensed Embalmer No. 4681

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.