

FILED FEB 3 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3945

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0860

1. PLACE OF DEATH a. COUNTY			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 St. Louis		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219
d. FULL NAME OF HOSPITAL OR INSTITUTION 2617 a Franklin Ave.			d. STREET ADDRESS (If rural, give location) 21 2617 a Franklin Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) OLYVIA		b. (Middle)	c. (Last) WILLIAMS		4. DATE OF DEATH (Month) (Day) (Year) 1-21-1953
5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	8. DATE OF BIRTH Jan. 12, 1895	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 0 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Henderson		13b. MOTHER'S MAIDEN NAME Gertrude Lambert		14. NAME OF HUSBAND OR WIFE none	
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. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Josephine Thomas 2617 a Franklin 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchitis 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 1-17-53
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 500x			
22. I hereby certify that I attended the deceased from January 17, 1953, to January 21, 1953, that I last saw the deceased alive on January 21, 1953, and that death occurred at 70 miles from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) James T. Aldrich M.D.		23b. ADDRESS 2607 a Franklin Ave.		23c. DATE SIGNED 1-25-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-26-53	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 26 1953	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home 2820 Stoddard St.			

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

(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 Leontine E. Culkin

Licensed Embalmer No. 4198

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.