

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27039

State File No.

V. S. No. 300

Rev. 10-48

FILED JUL 31 1953

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

6970

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

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 town) St. Louis		c. LENGTH OF STAY (in this place) OR TOWN		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		e. STREET ADDRESS (If rural, give location) 3614 1/2 Cozens			
3. NAME OF DECEASED (Type or Print) Sarah		a. (First)		b. (Middle)	
4. DATE OF DEATH 7 10 53		c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH March 20, 1866		9. AGE (In years last birthday) 87		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (City and State or Foreign Country) Louienville Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Katherine Henderson		14. NAME OF HUSBAND OR WIFE Allen B. Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Phillip Hawkins	
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) Carcinoma of Stomach 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.			
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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 151X	
22. I hereby certify that I attended the deceased from 7-9, 1953, to 7-10, 1953, that I last saw the deceased alive on 7-10, 1953, and that death occurred at 7:50 p.m., from the causes and on the date stated above.					
23a. SIGNATURE William Jimms, M. D.		(Degree or title)		23b. ADDRESS 2601 N. Whittier St.	
23c. DATE SIGNED 7-13-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-17-1953	
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County MO		25. FUNERAL DIRECTOR'S SIGNATURE Sneed Funeral Home	
DATE REC'D BY LOCAL REG. JUL 15 1953		REGISTRAR'S SIGNATURE Carl Smith MD		ADDRESS 3615 Easton	

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.....
Signature of Student Embalmer

Signed.....
Leroy W. Pannia

Licensed Embalmer No.....*4523*

P. O. Address.....*3880 East*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.