

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **3435**
0368

FILED FEB 2 1954

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

1. PLACE OF DEATH a. COUNTY D		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4056 Cote Brillante 2119	
3. NAME OF DECEASED (Type or Print) a. (First) Lottie b. (Middle) _____ c. (Last) Williams			4. DATE OF DEATH (Month) (Day) (Year) Jan. 11 1954
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 1, 1875
9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 4	IF UNDER 1 YEAR Days 10	IF UNDER 1 YEAR Hours _____ Min. _____
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 (City and State or Foreign Country) Gunnison, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME Simon Randell
13b. MOTHER'S MAIDEN NAME Marion ?		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME J. B. Williams	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignancy of G. I. Tract		INTERVAL BETWEEN ONSET AND DEATH _____	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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. Psychosis, secondary to Organic		19a. DATE OF OPERATION _____	
19b. MAJOR FINDINGS OF OPERATION Brain Disease		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) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 159X	
22. I hereby certify that I attended the deceased from 12-13 , 19 53 , to 1-11 , 19 54 , that I last saw the deceased alive on 1-11 , 19 54 , and that death occurred at 9:55 am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) J. J. Erwin M. D.		23b. ADDRESS 2601 N. Whittier St.	23c. DATE SIGNED 1-12-54
24a. BURIAL / CREMATION REMOVAL (Specify) Removal	24b. DATE Jan. 15, 1954	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county). (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REG. JAN 14 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 Bell Ave.	

WRITE PLAINLY--USING UNFAADING 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, Student Embalmer No. working under my personal supervision.."

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 26

P. O. Address.....
2769th

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.