FILED MAY 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17337

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4078

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: City Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is this house within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 508 Chestnut St. 2250

3. NAME OF DECEASED (Type or Print): a. (First) Alice b. (Middle) Francis c. (Last) Williams
4. DATE OF DEATH (Month) 5 (Day) 4 (Year) 54
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 19 1920
9. AGE (In years last birthday): 33 If under 1 year: Months Days If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and State or Foreign Country): Penna.
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME: Edward Siler
13b. MOTHER'S MAIDEN NAME: Unk.
14. NAME OF HUSBAND OR WIFE: Thomas Williams,
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: T. Williams ADDRESS: 508 Chestnut St.

MEDICAL CERTIFICATION

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."

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Lobar Pneumonia

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? 490X

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2:30 p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Patrick E. Taylor (Degree or title) Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 5.5.54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 5-5-54
24c. NAME OF CEMETERY OR CREMATORY: City
24d. LOCATION (City, town, or county) (State): Union Town Penna.

DATE REC'D BY LOCAL REG.: MAY 5 1954
REGISTRAR'S SIGNATURE: J. Earl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE: A.H. Hoppe ADDRESS: 4704 Washington Ave.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 41

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.