

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1269**

1. PLACE OF DEATH a. COUNTY ST Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY 2d 29	
b. CITY (If outside corporate limits, write RURAL and give township) Koch. Mo		c. CITY (If outside corporate limits, write RURAL and give township) ST Louis	
c. LENGTH OF STAY (in this place) 17 days		d. STREET ADDRESS (If rural, give location) 20 S 22nd St	
d. FULL NAME OF HOSPITAL OR INSTITUTION ROBERT KOCH HOSP			

3. NAME OF DECEASED (Type or Print) ETHEL	a. (First)	b. (Middle) -	c. (Last) WILLIAMS	4. DATE OF DEATH (Month) (Day) (Year) May 27 1954
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5. SEX F	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH JULY 19, 1913	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done 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) FOREST CITY, ARK	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME NEELEY BULLOCK deceased	13b. MOTHER'S MAIDEN NAME FRANCIS BURTS deceased	14. NAME OF HUSBAND OR WIFE LOUIS WILLIAMS
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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. UNK.	17. INFORMANT'S SIGNATURE OR NAME HOSP RECORD - Robert Koch Hosp	ADDRESS Koch. Mo
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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		INTERVAL BETWEEN ONSET AND DEATH 2 mo +
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 002X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) May 27 1954	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 11, 1954**, to **May 27, 1954**, that I last saw the deceased alive on **May 27, 1954**, and that death occurred at **7:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Frank Cohen	(Degree or title) MD	23b. ADDRESS Robert Koch Hosp	23c. DATE SIGNED 5/27/54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6-1-54	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	24d. LOCATION (City, town, or county) (State) ST LOUIS CO, MO
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DATE REC'D BY LOCAL REG. 6/1/54	REGISTRAR'S SIGNATURE Herbert D. ...	25. FUNERAL DIRECTOR'S SIGNATURE Bennie Love	ADDRESS 3103 Washington
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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 embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.