

FILED SEP 2 1954

STANDARD CERTIFICATE OF DEATH

State File No. **29318**Registrar's No. **7637**

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | State File No. 29318 | | Registrar's No. 7637 | | | |
| 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) 37 yrs | | 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) 1743 Marcus | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) Viola Williams | | | a. (First) | | b. (Middle) | | c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) 8 14 54 | | |
| 5. SEX Female | | 6. COLOR (OR RACE) Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH 11/15/1905 | | 9. AGE (In years last birthday) 48 | | # UNDER 1 YEAR Months Days 8 29 | # UNDER 2 HRS. Hours Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY same | | 11. BIRTHPLACE (City and State or Foreign Country) Hattiesburg, Mississippi | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13a. FATHER'S NAME James Chapman | | | 13b. MOTHER'S MAIDEN NAME Cora (?) | | | 14. NAME OF HUSBAND OR WIFE Dallas Williams | | | | | |
| 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. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Margaret Sanders, 1743a Marcus | | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH Undt. | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Cardiovascular Disease | | | | | | | | | | | |
| 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) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 331X | | | | | | | |
| 22. I hereby certify that I attended the deceased from 8-11 , 19 54 , to 8-14 , 19 54 , that I last saw the deceased alive on 8-14 , 19 54 , and that death occurred at 1:08A m., from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE Joseph Efron | | | | (Degree or title) M.D. | | 23b. ADDRESS 2601 N. Whittier | | | 23c. DATE SIGNED 8-16-54 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 9/19/54 | | 24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County Missouri | | | | | |
| DATE REC'D BY LOCAL REG. AUG 18 1954 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Gates, 4107 Finney Ave. | | | | | | |

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.....
Signature of Student Embalmer

Signed *Arthur L. Hellia*.....

Licensed Embalmer No. *429*.....

P. O. Address *4109 E*.....

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.