

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **32333**  
**8275**

FILED SEP 21 1954

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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: <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>25 1401 Blair</b>				
3. NAME OF DECEASED (Type or Print) <b>Luther</b>			a. (First)		b. (Middle)		c. (Last) <b>Williams</b>	
4. DATE OF DEATH		(Month)		(Day)		(Year)		
<b>9</b>		<b>4</b>		<b>54</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 3, 1892</b>		
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		IF UNDER 1 HR. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>LaGrange, Georgia</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13a. FATHER'S NAME <b>Ben Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Cornelius ?</b>		
14. NAME OF HUSBAND OR WIFE <b>Mattie Williams</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. _____				17. INFORMANT'S SIGNATURE OR NAME <b>Mattie Williams</b> ADDRESS <b>1401 Blair Ave.</b>				
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) <b>Uremia; Right Lower Lobe Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>						
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>490x</b>				
22. I hereby certify that I attended the deceased from <b>8-25</b> , 19 <b>54</b> , to <b>9-4</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>9-4</b> , 19 <b>54</b> , and that death occurred at <b>12:35 P.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Frank O. Richards</b> M.D.				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>9-8-54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Sept. 8, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>La Grange, Ga.</b>		
DATE REC'D BY LOCAL REG. <b>SEP 8 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. H. Randle &amp; Son 3133 Bell Ave.</b>				

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, *S. J. Hutton*

Licensed Embalmer No. *2691*

P. O. Address *2769 Chow*

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.