

FILED JAN 18 1955

STANDARD CERTIFICATE OF DEATH

State File No. **44133**
Registrar's No. **11798**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 6 mos.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Deaconess Hospital		e. STREET ADDRESS (If rural, give location) 3 6703 Oleatha	

3. NAME OF DECEASED (Type or Print)	a. (First) Corliss	b. (Middle) N.	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) Dec. 25, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 4, 1902	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor	10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (City and State or Foreign Country) St. Francis County, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Guy W. Williams	13b. MOTHER'S MAIDEN NAME Mabel E. Reynolds	14. NAME OF HUSBAND OR WIFE Ruth E. Williams (nee Hammond)
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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.	17. INFORMANT'S SIGNATURE OR NAME Ruth E. Williams, 6703 Oleatha,	ADDRESS 9
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchopneumonia		
	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. Malignant Astrocytoma of brain 1 yr			

19a. DATE OF OPERATION 10/54	19b. MAJOR FINDINGS OF OPERATION Astrocytoma of brain	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)
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? 193X

22. I hereby certify that I attended the deceased from **July 6, 1954**, to **Dec. 25, 1954**, that I last saw the deceased alive on **Dec. 25, 1954**, and that death occurred at **9:05a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>John J. Roth</i>	(Degree or title) M.D.	23b. ADDRESS 634 N. Grand Blvd.	23c. DATE SIGNED 12-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec. 28, 1954	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. DEC 27 1954	REGISTRAR'S SIGNATURE <i>Charles Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>C. Hoffmeister</i>	ADDRESS 6464 C. Hoffmeister Colonial Mortuary, Chippewa
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. John Roth
2:15 to 6
Mo. Theatre Bldg.

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 *Harry J. Schumacher*.....

Licensed Embalmer No. *2679*

P. O. Address *2814 S. Wood*

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.