

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **10045**
Registrar's No. **2058**

FILED MAR 31 1955

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____					
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)		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				STREET ADDRESS 20 2938 Madison		(If rural, give location) 2209					
3. NAME OF DECEASED (Type or Print) a. (First) Mazzie			b. (Middle)			c. (Last) Perry					
4. DATE OF DEATH (Month) (Day) (Year) 3 2 55		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH April 12, 1875			
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 1 MIN. Hours		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Montrose, Ark.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Van Williams			13b. MOTHER'S MAIDEN NAME Charlet Williams			14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Viola Myles		ADDRESS 2938 Madison Ave.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.</i>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Esophagus with Extension to Larynx.				INTERVAL BETWEEN ONSET AND DEATH Undt.			
				ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>							
				DUE TO (b) _____							
				DUE TO (c) _____							
				II. OTHER SIGNIFICANT CONDITIONS Tracheotomy; Gastrostomy <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>							
19a. DATE OF OPERATION None		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) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 150X							
22. I hereby certify that I attended the deceased from 2-9 , 19 55 , to 3-2 , 19 55 , that I last saw the deceased alive on 3-2 , 19 55 , and that death occurred at 8:30 Am. , from the causes and on the date stated above.											
23a. SIGNATURE Frank O. Richards (Degree or title) M.D.				23b. ADDRESS 2601 N. Whittier				23c. DATE SIGNED 3-2-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE March 7, 1955		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.					
DATE REC'D BY LOCAL REG. MAR 5 1955		REGISTRAR'S SIGNATURE J. Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE English Undertaking Co. ADDRESS 1123N. Taylor						

(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 embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Walter R. Williams*

Licensed Embalmer No. *492*
4554 Lexington
P. O. Address

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.