

FILED APR 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 10269
2948

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|---|--|--|--|--|--|--|--|-----------------|--|
| 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) 40 yrs | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | | | STREET ADDRESS (If rural, give location) 3636 Page | | 21190 | | | |
| 3. NAME OF DECEASED (Type or Print) Willie | | a. (First) | | b. (Middle) G. | | c. (Last) Sykes | | | |
| 4. DATE OF DEATH (Month) (Day) (Year) 3 30 55 | | 5. SEX F | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | | |
| 8. DATE OF BIRTH November 30, 1881 | | 9. AGE (In years last birthday) 73 | | IF UNDER 1 YEAR Months 4 Days _____ Hours _____ Min. _____ | | IF UNDER 24 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 Housewife | | 11. BIRTHPLACE (City and State or Foreign Country) Mobile, Alabama | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13a. FATHER'S NAME Albert Grayson | | 13b. MOTHER'S MAIDEN NAME Charlotte Andrews | | 14. NAME OF HUSBAND OR WIFE James Sykes | | | | | |
| 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. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Olivette Neal</i> 4311a Page Blvd. | | | | | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension. Hypertensive Cardiovascular disease. 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. Cerebral hemorrhage. | | | | INTERVAL BETWEEN ONSET AND DEATH Undt. | | | |
| 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) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 443x | | | | | |
| 22. I hereby certify that I attended the deceased from 3-24- , 19 55 , to 3-30- , 19 55 , that I last saw the deceased alive on 3-30- , 19 55 , and that death occurred at 6:00 a:m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE <i>Edw B. Williams</i> | | (Degree or title) M.D. | | 23b. ADDRESS 2601 N. Whittier Street | | 23c. DATE SIGNED 3-31-55 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Apr. 4, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary | | 24d. LOCATION (City, town, or county) (State) St. Louis, Missouri | | | |
| DATE REC'D BY LOCAL HEALTH DEPT. APR 1 1955 | | REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy R. Veal</i> | | ADDRESS 1123 N. Taylor | | | |

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 *Timothy R. Veal*.....

Licensed Embalmer No. *479*.....

P. O. Address *1123 N Taylor*.....

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.