

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10392

FILED MAR 18 1955

State File No.

BIRTH NO. _____ REG. DIST. **318** PRIMARY REG. DIST. **1003** Registrar's No. **1805**

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. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 21 2107 Cole	

3. NAME OF DECEASED (Type or Print)	a. (First) Leona	b. (Middle) —	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) 2 23 55
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5. SEX FEMALE	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 24, 1887	9. AGE (In years last birthday) 67 yrs 11 30	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME PAINCE SMITH	13b. MOTHER'S MAIDEN NAME HENRIETTA BROWN	14. NAME OF HUSBAND OR WIFE —
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME Uma Ware	ADDRESS 5538th Easton
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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		INTERVAL BETWEEN ONSET AND DEATH Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease Congestive Failure		
	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. Old Cerebrovascular Accident			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) (m.)	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 **12-29**, 19**55**, to **2-23**, 19**55**, that I last saw the deceased alive on **2-23**, 19**55**, and that death occurred at **2:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE Edw. B. Williams	(Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 2-24-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 3-1-55	24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	24d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS MO
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DATE REC'D BY LOCAL REG. FEB 25 1955	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	ADDRESS 2707 Stoddard St.
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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 *W. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 All*

.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.