

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28303

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1009 Registrar's No. 6512

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 town) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G. Phillips		e. STREET ADDRESS (If rural, give location) 12 4835 Fountain	
3. NAME OF DECEASED a. (First) Lemmer		b. (Middle) Williams	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 25, 1955	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH Dec. 10, 1896
9. AGE (In years last birthday) 58		10. UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Mississippi		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Lemmer		13b. MOTHER'S MAIDEN NAME Williams	
14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 497-69-256	
17. INFORMANT'S SIGNATURE OR NAME Robert Williams		ADDRESS 4835 Fountain	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis lower lobe of left lung; Anesthetic (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (c) (Narcotic), following operation for hernia at Homer G. Phillips Hospital	
19a. DATE OF OPERATION Jul 24 1955		19b. MAJOR FINDINGS OF OPERATION Accident	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hosp	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo 5.60.5			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jul 24 55 ?		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:15 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Patrick P. Taylor Carver		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 7-28-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 29, 1955	
24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) (State) Linnay Missouri	
DATE REC'D BY LOCAL REG JUL 28 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl Smith 1221 N Grand	

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 *William Blackman*.....

Licensed Embalmer No...390

P. O. Address 1721 N.....

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.