

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **28306**  
Registrar's No. **7317**

FILED SEP 8 1955

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 <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis,</b>		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 <b>Incarinate Word Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>4070a Lafayette Ave. 21790</b>			

3. NAME OF DECEASED (Type or Print) <b>MABEL</b>	a. (First)	b. (Middle) <b>****</b>	c. (Last) <b>WILLIAMSON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 22, 1955</b>
--	------------	-------------------------	-----------------------------	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>May, 14, 1908</b>	9. AGE (In years last birthday) <b>47</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 14 HRS. Hours	IF UNDER 1 HRS. Min.
----------------------	-------------------------------	--	---------------------------------------	---	---------------------------	--------------------------	---------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Model</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Brasser Bros Shoe</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Louisville, Ky.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
---	--	---	--

13a. FATHER'S NAME <b>John C. Williamson</b>	13b. MOTHER'S MAIDEN NAME <b>Emma Wilder son</b>	14. NAME OF HUSBAND OR WIFE
--	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John C. Williamson</b>	ADDRESS <b>4070a Lafayette Ave</b>
---	----------------------------------	---	------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of ovary</b>		<b>3 yrs.</b>
	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.			

19a. DATE OF OPERATION <b>Sept 5, 1955</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of ovary</b>	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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **Sept 5, 1955 to 22 Aug, 1955**, that I last saw the deceased alive on **21 Aug, 1955**, and that death occurred at **4:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. D. Workman</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>1657 S. Grand</b>	23c. DATE SIGNED <b>8-22-55</b>
---	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug. 24, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
--	--------------------------------	---	--

DATE REC'D BY LOCAL REG. <b>AUG 22 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. Kriegshauser</b>	ADDRESS <b>4228 S. Kingshighway Bl.</b>
---	--	---	---

(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 *William B. White*.....

Licensed Embalmer No. *425*

P. O. Address *4228 So King*

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.