

STANDARD CERTIFICATE OF DEATH

State File No. **39049**Registrar's No. **9833**

FILED NOV 23 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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 10 3953 Sullivan Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3953 Sullivan Ave		d. STREET ADDRESS (If rural, give location) 10 3953 Sullivan Ave.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Lula	b. (Middle)	c. (Last) Williams	Nov, 10, 1955	2.109	10
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar 9, 1893	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 8 Days 1
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) Macon, Miss.	
12. CITIZEN OF WHAT COUNTRY? USA.					

13a. FATHER'S NAME George Lasky	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE None
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 Lorene Fleming 3953 Sullivan Ave.

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 2 wks.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion	DUE TO (b) Hypertensive Heart.		9-5 yrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Arteriosclerosis			?
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION, 420.1		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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. 15, 1954**, to **Nov, 10, 1955**, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Russell W. White, M.D.	23b. ADDRESS 2424 N. Sarah	23c. DATE SIGNED 11-10-55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Nov, 14, 1955	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		

DATE REC'D BY LOCAL REG. NOV 10 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wright Funeral Home 3100 Easton Ave.
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed

W C Caudle

Licensed Embalmer No. 3489

P. O. Address. 4595 Alder

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.