

FILED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7403

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1927

|                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |                                                                           |                                                                                                                           |                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br>Missouri |                                                                           | b. COUNTY                                                                                                                 |                                                                          |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                           | c. CITY OR TOWN St. Louis                                                                                      |                                                                           | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |                                                                          |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4603 Page Avenue                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                           | e. STREET ADDRESS (If rural, give location) 4603 Page Avenue                                                   |                                                                           | 21190                                                                                                                     |                                                                          |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) Ruby<br>b. (Middle)<br>c. (Last) Williams                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                | 4. DATE OF DEATH (Month) (Day) (Year)<br>2 20 1956                        |                                                                                                                           |                                                                          |
| 5. SEX Female                                                                                                                                                                                                                                                                  | 6. COLOR OR RACE Negro                                                                                                                                                                                                                                                                                                                                                                                                    | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow                                                   | 8. DATE OF BIRTH May 5, 1902                                              | 9. AGE (In years last birthday) 53                                                                                        | IF UNDER 1 YEAR Months                                                   |
| IF UNDER 1 YEAR Days                                                                                                                                                                                                                                                           | IF UNDER 24 HOURS Hours                                                                                                                                                                                                                                                                                                                                                                                                   | IF UNDER 48 HOURS Mins.                                                                                        |                                                                           |                                                                                                                           |                                                                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY Private Home                                                                 | 11. BIRTHPLACE (City and State or Foreign Country) Conehatta, Mississippi |                                                                                                                           | 12. CITIZEN OF WHAT COUNTRY? USA                                         |
| 13a. FATHER'S NAME Ephran Harrison                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                           | 13b. MOTHER'S MAIDEN NAME Argain Smith                                                                         |                                                                           | 14. NAME OF HUSBAND OR WIFE - - -                                                                                         |                                                                          |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           | 16. SOCIAL SECURITY NO. none                                                                                   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Jessie Laws - 3750 Cook Ave. |                                                                                                                           |                                                                          |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                                                | <b>MEDICAL CERTIFICATION</b><br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <i>Mitral Insufficiency</i><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                                                                                |                                                                           |                                                                                                                           | INTERVAL BETWEEN ONSET AND DEATH<br>1-2-58                               |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                         | 19b. MAJOR FINDINGS OF OPERATION<br>410 X                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                           |                                                                                                                           | 20. AUTOPSY?<br>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) m.                                                                                                                                                                                                                             | 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 <u>2/10</u> , 19 <u>56</u> , to <u>2/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>56</u> , and that death occurred at <u>4 p. m.</u> from the causes and on the date stated above. |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |                                                                           |                                                                                                                           |                                                                          |
| 23a. SIGNATURE<br><i>James T. Aldrich M.D.</i>                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                           | (Degree or title) M.D.                                                                                         |                                                                           | 23b. ADDRESS<br><i>7627 A Franklin Ave</i>                                                                                | 23c. DATE SIGNED<br><i>2-21-56</i>                                       |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal                                                                                                                                                                                                                              | 24b. DATE<br>2/27/56                                                                                                                                                                                                                                                                                                                                                                                                      | 24c. NAME OF CEMETERY OR CREMATORY<br>Washington Park Cemetery                                                 | 24d. LOCATION (City, town, or county) (State)<br>St. Louis County Mo.     |                                                                                                                           |                                                                          |
| DATE REC'D BY LOCAL REG.<br>FEB 23 1956                                                                                                                                                                                                                                        | REGISTRAR'S SIGNATURE<br><i>Carl Smith MD</i>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>Atkins Bros. 3644 Finney Ave. |                                                                                                                           |                                                                          |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

Licensed Embalmer No. 269

P. O. Address 2769th

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.