

FILED MAY 25 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **18893**  
Registrar's No. **4196**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>4196</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		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>DOA Homer G. Phillips Hosp.</b>				e. STREET ADDRESS (If rural, give location) <b>4447 Delmar Blvd.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Rachel W</b>			b. (Middle) _____		c. (Last) <b>Williams</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 26 1956</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, (s) WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Nov. 28, 1891</b>		9. AGE (In years last birthday) Months Year If under 18 hrs. <b>64 4 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Tennessee</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary Lou Jackson 2608 A. Stoddard</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Infarction,</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Nephritis</b>						<b>10 yrs</b>	
		DUE TO (c) <b>Hypertrophy - Hypertension</b>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary Edema</b>						<b>6 mos</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>410K 595K</b>						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) _____		21e. INJURY OCCURRED WHILE AT NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>March</b> , 1956, to <b>4/17</b> , 1956, that I last saw the deceased alive on <b>4-17</b> , 1956, and that death occurred at <b>2:30P</b> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>D. N. Miller D.O.</b>				23b. ADDRESS <b>4114 Easton</b>		23c. DATE SIGNED <b>APR 28 1956</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4/30/56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>APR 28 1956</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. Rouse</b>		ADDRESS <b>1221 N. Grand</b>		

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 Valence Chom

Licensed Embalmer No. 475

P. O. Address 1521700

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.