

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22213

FILED JUN 29 1956

State File No.

318

1003

5884

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
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 township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis, Mo		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 220 2739 Madison				
3. NAME OF DECEASED (Type or Print) a. (First) Cary b. (Middle) Woodford c. (Last) Woodford			4. DATE OF DEATH (Month) (Day) (Year) 6 19 56					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 10-11-1891		
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months 08 Days 8		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) Clarksville Tenn.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13a. FATHER'S NAME William Cary		13b. MOTHER'S MAIDEN NAME Viry ?		14. NAME OF HUSBAND OR WIFE Lovie Cary	
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. _____		17. INFORMANT'S SIGNATURE OR NAME Lovie Cary ADDRESS 2739A Madison			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia					INTERVAL BETWEEN ONSET AND DEATH Undet.	
		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 Arteriosclerotic Heart Disease with Cardiac Insufficiency; Arteriosclerotic Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Gangrene of left Hand. Gangrene of left hand and forearm					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) 490 X				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
I hereby certify that I attended the deceased from 4-3- 1956, to 6-19- 1956, that I last saw the deceased alive on 6-19- 1956, and that death occurred at 5:10 a.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Edward B. Williams, M.D.				23b. ADDRESS 2601 North Whittier		23c. DATE SIGNED 6-19-56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-25-56		24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo		
DATE REC'D BY LOCAL REG. JUN 21 1956		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE A. L. Beal Und Co. ADDRESS 4303 Delmar				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE PERMANENT RECORD
Name # 3 Certified by Ed. B. Williams 6/19/56

