

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39928**
Registrar's No. **10403**

FILED NOV 29 1956

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1526 Bacon St.		d. STREET ADDRESS (If rural, give location) 1526 Bacon St.	
3. NAME OF DECEASED (Type or Print) a. (First) Hattie b. (Middle) Williams c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) 11 11 56	
5. SEX 3 F	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3/14/92
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Cleveland, Mississippi
12. CITIZEN OF WHAT COUNTRY U.S.A		13a. FATHER'S NAME Warner Washington	
13b. MOTHER'S MAIDEN NAME Eula ?		14. NAME OF HUSBAND OR WIFE Samuell Williams sr.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 500-30-0398	
17. INFORMANT'S SIGNATURE OR NAME Samuell Williams JR.		ADDRESS 1526 Bacon St.	
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) Cerebral Hemorrhage Coronary Thrombosis 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. 420.1	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. 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) (Minute)		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 11-9, 1956 , to 11-11, 1956 , that I last saw the deceased alive on 11-9, 1956 , and that death occurred at 2:00 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE A. B. Smith MD		23b. ADDRESS 11 N Jefferson	
23c. DATE SIGNED 11-13-56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11/16/56	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, County Mo	
DATE REC'D BY LOCAL REG. NOV 14 1956		25. FUNERAL DIRECTOR'S SIGNATURE Grant Johnson	
REGISTERAR'S SIGNATURE Carl Smith		ADDRESS 4352 Wash. Blvd.	

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
Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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