

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39932**
Registrar's No. **10214**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY OR TOWN ST. LOUIS c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Homer S. Phillips		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____ c. CITY OR TOWN ST. LOUIS d. STREET ADDRESS (If rural, give location) 2219 2341 Chestnut	
3. NAME OF DECEASED a. (First) Will b. (Middle) Williams c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) Nov 7, 1956	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 3, 1888
9. AGE (In years last birthday) 68 If under 1 year: Months _____ Days _____ If under 6 mos.: Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) Mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Sam Williams		13b. MOTHER'S MAIDEN NAME Sora Hamrick	
14. NAME OF HUSBAND OR WIFE Emma Williams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Sam Williams ADDRESS 2323 Market	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arterio Sclerotic Heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Disease; Hypertension DUE TO (c) _____ 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 420.0	
19c. 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 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:30 p.m., from the causes and on the date stated above.			
23a. SIGNATURE James M. Quinn (Degree or title) _____		23b. ADDRESS _____	
23c. DATE SIGNED 11/7/56			
24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov 9, 1956	
24c. NAME OF CEMETERY OR CREMATORY Cap Oak Cem		24d. LOCATION (City, town, or county) St. Louis (State) _____	
DATE REC'D BY LOCAL REG. NOV 8 1956		25. FUNERAL DIRECTOR'S SIGNATURE F. A. Green ADDRESS 4214 Selman	

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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
Student Embalmer

Signed..... *J. 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.