

FILED FEB 26 1957

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STATE FILE NUMBER

6759

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Registration District No. _____ Primary Registration District 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, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | | Length of stay in 1b | | d. STREET ADDRESS 1019 No. Whittier | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Chris Williams | | | | 4. DATE OF DEATH Month 2 Day 11 Year 57 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-6-1910 | | 9. AGE (In years last birthday) 46 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | | | 10b. KIND OF BUSINESS OR INDUSTRY CLEANING CO | | 11. BIRTHPLACE (City and state or country) INDIANOLA, MISS' | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME JAMES WILLIAMS | | | | 14. MOTHER'S MAIDEN NAME ANNIE | | | | | |
| 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 MATTIE TURNER | | | Address 4120 ASHLAND CT. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH undet. | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis | | | | | | | | | |
| DUE TO (c) 332x | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia | | | | | | | 19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____ | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE | |
| 21. I attended the deceased from 2-1-57 , to 2-11-57 and last saw him alive on 2-11-57 Death occurred at 4:20 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Hugh Waters , M. D. | | | | 22b. ADDRESS 2601 Whittier Street | | | 22c. DATE SIGNED 2-13-57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 2-13-57 | | 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK cem | | 23d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO | | | |
| 24. FUNERAL DIRECTOR A. F. WALTON | | | | ADDRESS 2707 SToddard | | 25. DATE RECD. BY LOCAL REG. FEB 14 '57 | | 26. REGISTRAR'S SIGNATURE Carl Smith MD | |

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ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 26. No symptoms with no history. AT

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *340*

P. O. Address *4575 A*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.