

Health, Welfare and Public Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

STANDARD CERTIFICATE OF DEATH

34322  
STATE FILE NUMBER  
8221  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

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 Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in lb 5 weeks	STREET ADDRESS 5920 Washington		(If outside, give location) Reside on Farm- Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MAY H. Middle H. Last WILLIAMSON			4. DATE OF DEATH Month Sept Day 2 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 9, 1869	9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) Macy, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Holly			14. MOTHER'S MAIDEN NAME Mary Davidson		
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. none	17. INFORMANT Address Jack E. Williamson 627 N. Taylor		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive nephrosclerosis 2 weeks</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Essential hypertension</i> DUE TO (c) <i>446x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 5 mo. 10 + yrs
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 a. m. p. m. Month, Day, Year					
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 <i>Oct 15, 1951</i> to <i>Sept 2, 1957</i> and last saw <sup>her</sup> <del>him</del> alive on <i>Sept 2, 1957</i> Death occurred at <i>11P:</i> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Barnett L. Tausig M.D.</i>			22b. ADDRESS <i>4500 Olive St.</i>		22c. DATE SIGNED <i>9-3-57</i>
23a. BURIAL, CREMATION, REINTERMENT (Specify)	23b. DATE <i>9/4/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>C.R. Lupton and sons 7233 Delmar Blvd</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 3 '57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i> <i>2186</i>	

(Licensed Embalmer's Statement on Reverse Side)

*Before name*

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 *Arnold W. Schoene*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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.