

FILED DEC. 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42789**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11091**

I. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN St. Louis	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA Homer G. Phillips		e. STREET ADDRESS (If rural, give location) 1209 N. Garrison	

3. NAME OF DECEASED (Type or Print) Rosie B. Williams	a. (First) _____ b. (Middle) B. c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1957
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 3, 1916	9. AGE (In years last birthday) 40	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Columbus, Mississippi	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Katherine Evans	14. NAME OF HUSBAND OR WIFE Fred Williams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Fred Williams	ADDRESS 1209A Garrison
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bacterial Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 491x		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 **908A m., from the causes and on the date stated above.**

23. SIGNATURE James H. Keely	23b. ADDRESS 1300 Blank	23c. DATE SIGNED 11-19-57
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24a. BURIAL, CREMATION REMOVAL (Specify) Removal	24b. DATE 11/21/57	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) Berkley, Missouri
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DATE REC'D BY LOCAL OFFICE NOV 19 1957	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. B. Roone	ADDRESS 1221 N. Grand Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *Malvin Blackburn*

Licensed Embalmer No. *396*

P. O. Address *1721 N. 2nd St.*

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