

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020286

STATE FILE NUMBER

WED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5631

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, MO.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Length of stay in lb 25		d. STREET ADDRESS (If outside, give location) 2290 2726a Franklin Ave.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle WILLIAMS Last			4. DATE OF DEATH Month MAY Day 29 Year 1958		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-07	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (City and state or country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Louis Rhodes		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE Amos Williams		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. 497-05-2032		17. INFORMANT Address Amos Williams 2726a Franklin Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____					600.0
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 5/27/58 to 5/29/58 and last saw her/him alive on 5/29/58 Death occurred at 6:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dr. William Burch M.D.		22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 5/29/58.	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 6-3-58		23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		24. FUNERAL DIRECTOR ADDRESS Dement & Son 2629-31 Cole St.		25. DATE RECD. BY LOCAL REG. MAY 29 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. <i>m.j.b.</i>					

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

INVESTIGATION

STATE OF

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

RECORDS

DEPARTMENT

STATE

INVESTIGATION

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DEPARTMENT OF HEALTH

STATE OF

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

RECORDS

DEPARTMENT

STATE

STATE OF

OR

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 *Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.