

XC-3227 489
SL 17181

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027583
STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7431

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN MAPLEWOOD 4504	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) 27 2019 BERKLEY AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last TOM WILLIAMS		4. DATE OF DEATH Month Day Year JULY 28, 1958	
5. SEX MALE 2	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 67
11. BIRTHPLACE (City and state or country) BROOKHAVEN, MISSISSIPPI		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME BILL WILLIAMS		13b. MOTHER'S MAIDEN NAME LAURA (UNKNOWN)	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE WITH PYELONEPHRITIS AND MALIGNANT HYPERTENSION. DUE TO (b) _____ DUE TO (c) _____ 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 445X
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 p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>VA</u> to <u>7/28/58</u> and last saw him alive on <u>7/28/58</u> Death occurred at <u>10:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Vincent A. Codiga</u> (Degree or title) VINCENT A. CODIGA M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
22c. DATE SIGNED 7/29/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 1, 1958	
23c. NAME OF CEMETERY OR CREMATORY National Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo	
24. FUNERAL DIRECTOR John W Hemphill 408S Fillmore Kirkwood 22. Mo.		25. DATE RECD. BY LOCAL REG. JUL 30 1958	
26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>			

Social, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

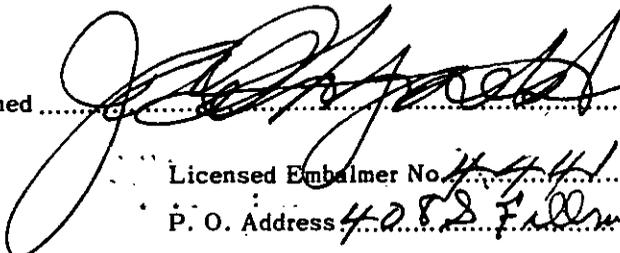
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4441
P. O. Address 4288 Fallman

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.