

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042595

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 1 1958		Registration District No. 317	Primary Registration District No. 541	Registrar's No. 3032
1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 CLAYTON		Inside Limits OR Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SO. KINLOCH 400'	Inside Limits OR Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP		Length of stay in 1b 5 DAYS	d. STREET ADDRESS 1107 SCOTT	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Willie			4. DATE OF DEATH 11-16-58	
5. SEX MALE		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 1-28-1886
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY unemp.	11. BIRTHPLACE (City and state or country) TURNER, ARK.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME HENRY WILLIAMS		14. MOTHER'S MAIDEN NAME MARGARET Boyce		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. UNK.	17. INFORMANT MRS. WILLIAM 1107 SCOTT	
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 VASCULAR ACCIDENT Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CEREBRAL ATHEROSCLEROSIS - 331X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
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 11-10-58, to 11-16-58 and last saw her/him alive on 11-16-58 Death occurred at 1:45P m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE W. D. Holley M.D.		22b. ADDRESS 601 S. BRENTWOOD CLAYTON		22c. DATE SIGNED 11-16-58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-21-58	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS CITY MO
24. FUNERAL DIRECTOR A. F. WALTON 2707 STODDARD		25. DATE RECD. BY LOCAL REG. 11-20-58		26. REGISTRAR'S SIGNATURE Herbert P. Danke M.D.

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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 *W. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address: *4575 ab*

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.