

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046517
STATE FILE NUMBER
12008

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Enroute To Hospital</i>		2. USUAL RESIDENCE, (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		c. CITY OR TOWN <i>St Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Homer H. Phillip</i>		d. STREET ADDRESS (If outside, give location) <i>219 3201 PINE</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Leo Williams</i>		4. DATE OF DEATH Month Day Year <i>12 9 58</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-25-1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>66</i> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <i>MISSISSIPPI</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>UNKNOWN</i>		13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
14. NAME OF HUSBAND OR WIFE <i>Laura Williams</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>420-14-7075</i>		17. INFORMANT Address <i>Laura Williams 3201 Pine</i>	
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>Coronary Pericarditis</i> DUE TO (b) _____ DUE TO (c) <i>434.3</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
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 _____ to _____ and last saw her alive on _____ Death occurred at <i>1030 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Street & Taylor Caron</i>		22b. ADDRESS <i>1300 Clark</i>	
22c. DATE SIGNED <i>12/13/58</i>		23. NAME OF CEMETERY OR CREMATORY <i>FATHER DICKSON KEENE BUND MO</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-15-58</i>	
24. FUNERAL DIRECTOR <i>Hill & Radford</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 13 58</i>	
26. REGISTRAR'S SIGNATURE <i>J. Earl Smith MD</i>		27. (H.T.)	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Leroy W. Bannister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.