

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007802

STATE FILE NUMBER

2 1479

FEB 26 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
1-57
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9 4
6

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) St. Louis		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 Homer G. Phillips		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2227 Lucas
3. NAME OF DECEASED (Type or print) First Viola Middle Williams Last Williams			4. DATE OF DEATH Month 2 Day 8 Year 59
5. SEX Female	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 NOV. 1, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 59 YRS IF UNDER 1 YEAR: Months 3 Days 7 IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (City and state or country) MERIDIAN, MISS		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13a. FATHER'S NAME Will PERRY		13b. MOTHER'S MAIDEN NAME KATHERINE BLUFORD	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) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Ledell BRAXTON Address 2227^a LUCAS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 443X 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 type="checkbox"/> NO <input checked="" 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 <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 2-6-59 to 2-8-59 and last saw her alive on 2-8-59 Death occurred at 6:03 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M. Lane (degree or title) D		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 2-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 2-14-59	23c. NAME OF CEMETERY OR CREMATORY Booker WASHINGTON Cem.	23d. LOCATION (City, town, or county) (State) EAST ST. LOUIS, ILL.
24. FUNERAL DIRECTOR A.F. WALTON ADDRESS 2707 Stoddard St.		25. DATE RECD. BY LOCAL REG. FEB 11 59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4525 Aldine*

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.