

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015960

STATE FILE NUMBER 2-3986  
Registrar's No.

FILED MAY 6 1959

Registration District No. Primary Registration District No.

300  
-57

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|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b><br>b. COUNTY                              |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |  | c. CITY OR TOWN <i>St. Louis</i>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>   |  | d. STREET ADDRESS <b>3847a Ashland</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Anna</b> Middle <b>Williams</b> Last <b>Williams</b>   |  | 4. DATE OF DEATH<br>Month <b>3</b> Day <b>18</b> Year <b>59</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-11-1862</b>   |
| 9. AGE (In years last birthday)<br><b>96</b>  | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS<br>Days   | IF UNDER 24 HRS<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>At home</i>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Tenn.</b>  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13a. FATHER'S NAME<br><b>Jim Turner</b>   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Mary Clay</b>   |  | 14. NAME OF HUSBAND OR WIFE   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>Mrs Mary A. Jett</i>  |  | Address<br><b>R.R.L. 2601 Whittier St.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>undet.</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   | <b>+50.0</b>  |
| 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?<br>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<br>Hour _____ Month, Day, Year _____<br>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 <b>12-26-58</b> to <b>3-18-59</b> and last saw her <b>OK</b> alive on <b>3-18-59</b><br>Death occurred at <b>9:59</b> P m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE <i>Paul M. Larson</i> (Degree or title)<br><b>Paul M. Larson</b> , M.D.  |  | 22b. ADDRESS<br><b>2601 Whittier Street</b>   | 22c. DATE SIGNED<br><b>3-20-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br><b>4-30-59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>                            |
| 24. FUNERAL DIRECTOR<br><b>Rowland Aker Mortuary Service</b><br><b>4104 Manchester Ave.</b><br><b>St. Louis 10, Mo.</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>APR 23 '59</b>   | 26. REGISTRAR'S SIGNATURE<br><i>W. H. Smith</i> , 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 .....

Licensed Embalmer No.....

P. O. Address .....

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.