

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019779
State File No.

FILED JUN 15 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. **2 5320**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give town or township)		a. STATE	b. COUNTY
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS	

St Louis, Missouri
St. Louis
Waller Phillips
4047 Finney Ave.

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX			8. DATE OF BIRTH		
6. COLOR OR RACE			9. AGE (In years last birthday) IF UNDER 1 YEAR Days Hours Min.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			11. BIRTHPLACE (State or foreign country)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12. CITIZEN OF WHAT COUNTRY?		
10b. KIND OF BUSINESS OR INDUSTRY			14. NAME OF HUSBAND OR WIFE		

ISAAC Williams
June 2-1959
Male - Negro
Widowed
Feb-3-1894
65 3 29
Porter G.L. CARBON
Pulaski Tenn.
USA
George Williams
UNKNOWN DEAD

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	

no no 492-03-7743 C.W. Gardine 5712 Julian St. Low

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		1 day	
		DUE TO (b)		1 1/2	
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or conditions causing death.		4201	

Myocardial Infarction
Hypertension

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Jan 1, 1959, to June 1, 1959, that I last saw the deceased alive on Jan 1, 1959, and that death occurred at 2:21 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State)		24e. NAME OF CEMETERY OR CREMATORY		24f. LOCATION (City, town, or county) (State)	

Walter A. Young (M.D.) 4635 Easton 6/2/59
Removal 6-5-1959 Father-Dickson Cem. Kirkwood Mo. 22

DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
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JUN 3 1959 Carl Smith, M.D. Moser Adams 3849 Windsor

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
Student Embalmer

Signed _____

F. G. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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 this body is not embalmed, fact should be so stated above.