Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-023538
STATE FILE NUMBER

ISSUED JUL 1 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 5751

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Saint Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 5236 Vernon Ave. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: Saint Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5236 Vernon Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Estella — Middle: Wolff — Last: Williamson
4. DATE OF DEATH: Month: June — Day: 15 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 4, 1906
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Chrystal Springs, Miss.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME: Charles Wolff
13b. MOTHER'S MAIDEN NAME: Charlotte Moncure
14. NAME OF HUSBAND OR WIFE: Hershel Williamson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hershel Williamson — Address: 5236 Vernon Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sarcoma of uterus — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 174X
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Sept. 3/58 to June 15 and last saw her/him alive on June 5, 1959
Death occurred at approximately 9 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Alfred Sherman (Degree or title) M.D.
22b. ADDRESS: 630 S. Kingshighway
22c. DATE SIGNED: 6/16/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6-18-59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Metropolitan Funeral System, Inc. — ADDRESS: 5010 Enright
25. DATE RECD. BY LOCAL REG.: JUN 17 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.