

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 13 1959

59-027361

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7240** STATE FILE NUMBER

DED

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| 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) OR TOWN St. Louis | | Length of stay in 1b | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2708 Hickety |
| | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|---|--------|--|--|-------|-----|------|
| 3. NAME OF DECEASED (Type or print) Otto Williams | | | 4. DATE OF DEATH Month 8 Day 2 Year 59 | | | |
| First | Middle | | Last | Month | Day | Year |

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|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 6/19/1899 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---------------------------|------------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Hot Springs Ark. | 12. CITIZEN OF WHAT COUNTRY U.S.A |
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| 13a. FATHER'S NAME Frank Williams | 13b. MOTHER'S MAIDEN NAME Elizabeth Pierce | 14. NAME OF HUSBAND OR WIFE Ruth Williams |
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| 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. 500-18-3559 | 17. INFORMANT Address Viola Tucker 2708a Hickory |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Ca of bladder <i>Epidermoid Ca of Bladder</i> | | INTERVAL BETWEEN ONSET AND DEATH undet |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____ | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 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 |
|--|--|------------------------------|--------|-------|

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| 21. I attended the deceased from 4-26-59 to 8-2-59 and last saw <input checked="" type="checkbox"/> alive on 8-2-59 Death occurred at 4:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE L. J. Clanton (Degree or title) <i>L. J. Clanton, M.D.</i> | 22b. ADDRESS 2601 Whittier Street | 22c. DATE SIGNED 8-4-59 |
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|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 8/6/59 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | 23d. LOCATION (City, town, or county) (State) St. Louis, County, Mo |
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| 24. FUNERAL DIRECTOR Grant Johnson | ADDRESS 4352 Wash. Blvd. | 25. DATE RECD. BY LOCAL REG. AUG 4 '59 | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> S.P. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963
P. O. Address 4214 So. Elm

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.