

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

59-027363

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 7030**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST. CLAIR</b>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>7 DAYS</b>		c. CITY OR TOWN <b>E. ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VAH, 915 NO. GRAND AVE.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2030 MC CASLAND AVE.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>TOMMY E. WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>JULY 28, 1959</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/24/06</b>		9. AGE (last birthday) <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor, JANITOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Park Lock Company</b>		11. BIRTHPLACE (City and state or country) <b>ALVION, MISSISSIPPI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>ELIJAH WILLIAMS</b>				13b. MOTHER'S MAIDEN NAME <b>LIZZIE WASHINGTON</b>				14. NAME OF HUSBAND OR WIFE <b>MAGGIE WILLIAMS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-II</b>				16. SOCIAL SECURITY NO. <b>425-09-5365</b>		17. INFORMANT Address <b>VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) - - -			
DUE TO (c) - - - <b>420.0</b> - - -										-			
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							
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 s.m. p.m. Month, Day, Year													
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					
21. I attended the deceased from <b>7/28/59</b> to <b>7/28/59</b> and last saw him <b>live</b> on <b>7/28/59</b> Death occurred at <b>12:00 NOON</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>John H. Winter, M.D.</b>						22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>			22c. DATE SIGNED <b>7/28/59</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7/31/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Armstead Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Clarksdale, Mississippi</b>							
24. FUNERAL DIRECTOR <b>Narvon Offner</b> Address <b>2114 Mo. Ave., E. St. Louis, Ill.</b> (Licensed Embalmer's Statement on Reverse Side)				25. DATE RECD. BY LOCAL REG. <b>JUL 30 '59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>mje</b>							

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 Frank Prako

Licensed Embalmer No. 4356

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.