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173

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-034500

STATE FILE NUMBER

2 8402

FILED VS SEP 22 1959

Registration District No. Primary Registration District No.

Registrar No.

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		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2209 Division St.	
Length of stay in 1b		Reside on Farm # 606 No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last William Edward Williams			4. DATE OF DEATH Month Day Year 9 8 59
5. SEX M	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 8/12/14
9. AGE (In years last birthday) 45		10. FUNDING YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Meredian Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Deceased	
13b. MOTHER'S MAIDEN NAME Annie Allen		14. NAME OF HUSBAND OR WIFE Mazelle Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War 12		16. SOCIAL SECURITY NO. 495-18-8115	
17. INFORMANT Annie Williams		Address 2209 Division St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Subdural & Subarachnoid Hemorrhage (Traumatic); Cirrhosis of the Liver; apparently caused in fall. EXACT TIME, PLACE, COULD NOT BE DETERMINED: Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ACCIDENT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 904.9 48			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) See Above		20c. TIME OF INJURY Hour 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.) 290 Unk.	
20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 11:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS 1200 Clark	
22c. DATE SIGNED 9/9/59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 9/14/59		23c. NAME OF CEMETERY OR CREMATORY Washington Park	
23d. LOCATION (City, town, or county) St. Louis, County, Mo.		(State)	
24. FUNERAL DIRECTOR Grant Johnson		ADDRESS 4352 Wash. Blvd.	
25. DATE RECD. BY LOCAL REG. SEP 11 1959		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoKS 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NYS
SEP 12 1966

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 *F. A. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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