

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2, 2369** STATE FILE NUMBER **60-009075**

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, Missouri.		Length of stay in 1b 2 years		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4243 San Francisco Avenue,			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4243 San Francisco Avenue,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Della Williams				4. DATE OF DEATH Month Day Year February 27, 1960.				
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12/7/1877	9. AGE (last birthday) 82	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Hamilton County, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME John H. Douglas			13b. MOTHER'S MAIDEN NAME Sarilda Deen		14. NAME OF HUSBAND OR WIFE Robert H. Williams, dec'd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John D. Williams, 800 South Hanley Road,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage							INTERVAL BETWEEN ONSET AND DEATH 1 week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) General Arteriosclerosis		DUE TO (c) 331x		10 yrs.		
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 checked="" 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 a.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 JAN 57 8:45 AM to Feb 27 60 and last saw her alive on Feb 25 60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Paul Knipsey Webb M.D.				22b. ADDRESS 721 Olive St. St. Louis Mo		22c. DATE SIGNED 2-27-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/27/60	23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION (City, town, or county) (State) McLeansboro, Illinois				
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington			25. DATE RECD. BY LOCAL REG. FEB 29 1960	26. REGISTRAR'S SIGNATURE Coal Smith, M.D. <i>mjc.</i>				

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 Etton St. Penick

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.