

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 17 1960

2 2649 60-013407  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>1448 A. Burd Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>JESSIE</b> Middle <b>IG</b> Last <b>WILLIAMS</b>			<b>4. DATE OF DEATH</b> Month <b>MARCH</b> Day <b>2</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Col.</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/22/94</b>	<b>9. AGE (last birthday)</b> <b>65</b>	<b>IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>10</b>	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Disability</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Post Office</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Union, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA.</b>
<b>13a. FATHER'S NAME</b> <b>Ben Anderson</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>		

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT</b> Address <b>Chicago 21, Ill</b> <b>Thornly B. Williams 6349 S. Eggleston</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BLEEDING ESOPHAGEAL VARICES</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CIRRHOSIS OF LIVER</b>  DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>  <b>6 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  <b>CHRONIC MYELOCYTTIC LEUKEMIA</b>		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

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY _____ STATE _____
<b>21. I attended the deceased from</b> <b>MARCH 19, 1959</b> to <b>MARCH 2, 1960</b> and last saw her/him alive on <b>JAN. 14, 1960</b> Death occurred at <b>10:12 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

<b>22a. SIGNATURE</b> (Degree or title) <i>C. Williams, M.D.</i> M. D.	<b>22b. ADDRESS</b> <b>BARNES HOSPITAL</b>	<b>22c. DATE SIGNED</b> <b>3/3/60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE</b> <b>3/10/60</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Park Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Co. Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Wright Funeral Home 3100 Easton Ave.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>MAR 7 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Loan Smith, M.D.</i>
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BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

DOCUMENT

STATE OF CALIFORNIA

**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 Arthur P. Hernandez

Licensed Embalmer No. 4221  
P. O. Address 3100 Costa

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.