

318

1003

8133

-60-033079

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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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 type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2123 O'Fallon, Apt. 602 |
| 3. NAME OF DECEASED (Type or print) First Cheila Middle Ann Last Williams | | 4. DATE OF DEATH Month 8 Day 11 Year 60 | |

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| 5. SEX Fem. | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-10-60 | 9. AGE (last birthday) IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours 13 Min. 21 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Saint Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY USA |

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| 13a. FATHER'S NAME Faryene Williams | 13b. MOTHER'S MAIDEN NAME Emma Jones | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT <i>Mr. May D. [Signature]</i> | Address 2601 N. Whittier |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Adrenal Hemorrhage | | |
| DUE TO (b) Atelectasis with Aspiration Syndrome | | |
| DUE TO (c) 762.0 | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) G. I. Tract Abnormalities | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 | 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 8-10-60 to 8-11-60 and last saw her ^{her} alive on 8-11-60 Death occurred at 6:05 a. on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) M. D. | 22b. ADDRESS 2601 N. Whittier | 22c. DATE SIGNED 8-15-60 |

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|-------------------------------------------|---------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE AUG 31 1960 | 23c. NAME OF CEMETERY OR CREMATORY Anatomical Board | 23d. LOCATION (City, town, or county) St. Louis, Mo. | (State) |
|-------------------------------------------|---------------------------------|---------------------------------------------------------------|----------------------------------------------------------------|---------|

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| 24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-064 Manchester | 25. DATE RECD. BY LOCAL REG. AUG 18 1960 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M. D. |
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.